MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9

03011

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montg Co

City or town: Washington Grove, (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montg

City or town: Washington Grove
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Annie Virginia Achenbach

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William Achenbach

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 22 1856

8. AGE: Years	Months	Days	If less than one day
1856 88	4	16	hrs. min.

9. Birthplace: Penn
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business:

FATHER
12. Name: William Harrar
13. Birthplace: Penn

MOTHER
14. Maiden name: Martha Roger
15. Birthplace: Penn

16. Informant: Leo H Achenbach
Address: Washington Grove, Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/11/45 (month) (day) (year)

Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg Md,

16. Funeral director: Ernest C Gartner
Address: Gaithersburg. Md,

19 March 9 1945 (Date rec'd by registrar) Alsuda G Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8th 1945, at 3 45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1939 to March 8. 1945 and that I last saw h[illegible] alive on March 7. 1945

Immediate cause of death	DURATION
Arteriosclerotic Heart	15 years
Due to: Hemorrhaged Arteriosclerosis	
Due to:	
Other conditions: Arterio Sclerosis	10 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M McKendree Bayer M.D.
M. D. or other

Address: Damascus - Maryland Date signed 3/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

03012

CERTIFICATE OF DEATH

Reg. Dist. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest towo)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred: Washington Sanitarium + Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give resideoce of mother)

State: Maryland County:

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest towo)

Street No.: Route 1

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Mrs. Lillian Acorn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Mr. George Acorn deceased

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 14, 1864

8. AGE:

Years	Months	Days	If less than one day
80	10	20	hrs. min.

9. Birthplace: Cape Cod, Mass. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: at home

FATHER

12. Name: Unknown

13. Birthplace: Mass.

MOTHER

14. Maiden name: Pattie Knowles

15. Birthplace: Mass.

16. Informant: Records Washington San. + Hospital

Address: Takoma Park, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Mar 6 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington D C

18. Funeral director: Deal Funeral Home

Address: 4812 Ga Ave Wge DC

19. March 6 1945 (Date rec'd by registrar) J. Gillis Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1945 at 5:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-1-45 1945 to 3-6-1945 and that I last saw h[illegible] alive on 3-5-45 1945

Immediate cause of death: Cerebral thrombosis (Disease or condition directly causing death) meaning: Cerebral arteriosclerosis. DURATION: ? yrs.

Due to: 1. Undetermined. CHF

Due to: Arteriosclerosis

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. M. Glenn M.D. M. D. or other

Address: Silver Spring, Md. Date signed: 3-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03013

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Mongtomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one month 27 days
Hospital, institution, or street address where death occurred:
US NAVAL HOSPITAL, Bethesda, Md.
How long in hospital or institution? one month 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: N.Y. County:
City or town: New York City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1244 Grand Concourse
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ALBURGER, Ralph Coleman, Major USMC

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Betty Alburger
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 22 May 1888

8. AGE: Years	Months	Days	If less than one day
56	9	16	hrs. min.

9. Birthplace: Penn.
(Town, county, and state)
10. Usual occupation: US Marine Corps
11. Industry or business

FATHER
12. Name: Abraham Coleman
13. Birthplace: Pa.

MOTHER
14. Maiden name: Lena Goekeler
15. Birthplace: Pa

16. Informant: Wife: Mrs. Betty Alburger
Address: 5522 Wisconsin Avenue, Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 3-10-45 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.

18. Funeral director: W. W. Chambers
Address: 1400 Chapins Street, N. W., Wash., D.C.

19. 8 March 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 March 1945 at 0125 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 January 1945, to 8 March 1945 and that I last saw him alive on 7 March 1945

Immediate cause of death	DURATION
Coronary Thrombosis	9 days
Due to	
Due to	
Other conditions: Cerebral Thrombosis	7 mo

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: no done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. P. McCombs, Lt.(MC) USNR
Address: US Naval Hospital, Bethesda, Md. M. D. or other Date signed: 3-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

03914

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
28 Prospect
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 28 Prospect
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME William James Avery

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Ida Mae
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 25, 1864

8. AGE: Years 80 | Months 10 | Days 3 | If less than one day ..... hrs. ..... min.

9. Birthplace Canada
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name James S. Avery
13. Birthplace —

MOTHER
14. Maiden name Margaret Bradley
15. Birthplace —

16. Informant Mrs E. J. Wakefield
Address 28 Prospect St Kensington, Md.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 3/29/45 (month) (day) (year)
Cemetery or crematory Watertown N. Y.
Location Watertown, N. Y.

19. Funeral director Wm Reuben Plumpton
Address 7557 Wis. Ave. Bethesda

19. 3/28 19 45 Mrs E. John Reed Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 19 45, at 9:35 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1941, to March 28 1945
and that I last saw h— alive on March 28 1945

Immediate cause of death	DURATION
Hypertensive Heart Disease	
Due to	
Due to	
Other conditions General arterio-sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Marion Bamford M.D.
M. D. or other
Address 9601 Sutton Place Date signed 3/28/45
Heart & Hypertension

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

03015

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Monty.
City or town: Brookmont, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County: Washington
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4113 W. St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Arthur H. Axford

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Singles

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 5, 1927

8. AGE: Years	Months	Days	If less than one day
17			hrs. min.

9. Birthplace: Newark, N.J. (Town, county, and state)
10. Usual occupation: Western High School Student
11. Industry or business

FATHER
12. Name: Gilbert H. Axford
13. Birthplace: Newark

MOTHER
14. Maiden name: Helen M. Axford.
15. Birthplace: Easton, Pa.

16. Informant: Mrs. Helen M. Axford
Address: 4113 W. St. N.W.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof: 4/2/45 (month) (day) (year)
Cemetery or crematory: Easton Pa. Cem.
Location: Easton, Pa.

18. Funeral director: Wm Reuben Pumphrey
Address: 7557 Wis. Ave. Bethesda

19. 4/1/45 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 30 1945, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. med. Exam Case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
a. Asphyxia	
Due to: b. Drowning (accidental)	—
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accidental Date of: 3-30-45
Where did injury occur? Brookmont (City or town) Mont. (County) Md. (State)
Injured at home, farm, industry, public place (where?): C+O Swim canal
Means of injury: drowning Injured at work? no

23. SIGNATURE: Frank J. Broshat M.D.
Dep. Med. Examiner
M. D. or other
Address: Hagerstown Md. Date signed: 3-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of year of birth of deceased is shown on FILM No. G 94 MAY 15 1945

03016

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Olney / Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: The Montgomery County General Hospital Inc.
How long in hospital or institution? 43 day's.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Laurel R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: David M. Barnes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Mrs. Hettie M. Barnes.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 18, 1873 1878

8. AGE: Years	Months	Days	If less than one day
66	2	15	hrs. min.

9. Birthplace: Carroll County, Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: —
12. FATHER — Name: Joseph Barnes
13. FATHER — Birthplace: — — — — — —
14. MOTHER — Maiden name: Elizabeth Cruise
15. MOTHER — Birthplace: — — — — — —
16. Informant: Hospital records
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-6-45 (month) (day) (year)
Cemetery or crematory: Emanuel Cem.
Location: Sandy Spring, Md.
18. Funeral director: Lloyd Kaiser
Address: Laurel, Md.
19. 3-6- 1945 (Date rec'd by registrar) Gertrude B. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 1945, at 7:35 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 18 1945, to March 3 1945, and that I last saw h[illegible] alive on March 3 1945

	DURATION
Immediate cause of death: General peritonitis	4 days
Due to: Acute gangrenous appendicitis	13 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Acute gangrenous appendicitis
Date of op. Feb. 20, 1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Sandy Spring, Md. Date signed 3/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

03017

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, Institution, or street address where death occurred: 8919 Colesville Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8919 Colesville
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: BARRELL, EDWARD PARK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: EDNA DUNCAN

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 16 - 1864

8. AGE: Years: 80 | Months: 5 | Days: 1. | If less than one day: ..... hrs. ..... min.

9. Birthplace: SOUTH TURNER MAINE (Town, county, and state)

10. Usual occupation: EDUCATOR —

11. Industry or business: STETSON - UNIVERSITY

FATHER
12. Name: BARRELL, CHARLES HAYDEN
13. Birthplace: So. TURNER, MAINE

MOTHER
14. Maiden name: CRAFTS, LAURA JANE
15. Birthplace: AUBURN, MAINE

16. Informant: Mrs. EDNA BOGER WOOD

Address: 8919 COLESVILLE

17. Removal (Burial, cremation, or removal. Which?) Date thereof: MAR 17 - 1945 (month) (day) (year)

Burial Cemetery or crematory: Rock Creek Cemetery Mar 19 1945

Location: Wash D.C.

18. Funeral director: The S H Hines Co

Address: 2401 - 14th St NW -

19. Mar. 17 1945 (Date rec'd by registrar) Josephine M. Schaefle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 17 1945, at 6 15 P.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from MARCH 17 1945, to MARCH 17 1945

and that I last saw h. I.M. alive on MARCH 17 1945

Immediate cause of death: CEREBRAL HEMORRHAGE — DURATION: FEW MINS

Due to: NEPHRITIS - CHRONIC — 20 DAYS

Due to: — 2 YRS.

Other conditions: SENILITY — 2 YRS.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C W Whitehill MD (M. D. or other)

Address: Suburban Nat'l Bank Blg. Date signed 3-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03018

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
8560 Georgia Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8560 Georgia Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Raymond Earl Barrett

3.(b) Social Security Number: 212-24-2620

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	divorced

6.(b) Name of husband or wife: Bertha E.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 4, 1898

8. AGE: Years	Months	Days	If less than one day
46	5	2	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Owner + Manager of

11. Industry or business: Barrett Filling Station

FATHER — 12. Name: Elbert Barrett

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary D. Kramer

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Mary E. Crismond

Address: 8560 Georgia Ave., S.S., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 9, 1945 (month) (day) (year)

Cemetery or crematory: St. Mark's

Location: Fairland, Md.

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19. Mar 8 1945 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAR. 6TH 1945, at 9:32 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-15 1945, to ..... 19....; and that I last saw him alive on 3-6 1945

	DURATION
Immediate cause of death: Subarachnoid Hemorrhage	30 mins
Due to: Hypertensive Heart Disease	3 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Kenneth F. Laughlin M.D.
M. D. or other

Address: Suburban Bank Bldg. Date signed: 3-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

03019

Reg. Dist. No. 21

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

1. PLACE OF DEATH:

County Montgomery

City or town Damascus

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Damascus

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Franklin Edward Beall

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ethel Mariam Beall

6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Sept 2. 1872

8. AGE: Years	Months	Days	If less than one day
72	6	13	...hrs. ...min.

9. Birthplace Montgomery County (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Dairy Farming

FATHER 12. Name John Beall

FATHER 13. Birthplace Montgomery County

MOTHER 14. Maiden name Somerville Virginia

MOTHER 15. Birthplace Montgomery County

16. Informant Ethel M. Beale

Address Damascus Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 18 1945 (month) (day) (year)

Cemetery or crematory Damascus Mem.

Location Damascus Md.

18. Funeral director J. B. Beall, Inc.

Address Damascus, Md

19. Mar 17 1945 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 15 1945, at 11-30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 15 1945, to Mar 15 1945 and that I last saw h... alive on Mar 15 1945

Immediate cause of death	DURATION
Due to Thrombosis, Due to Coronary Occlusion	Half hr. Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address Taylorsville Md Date signed Mar 14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (168)

CERTIFICATE OF DEATH

03020

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours

Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Penn. County

City or town Duboistown,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2965 Cochran Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME BENNETT, James Richard, Cpl. USMC

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1925

8. AGE: Years	Months	Days	If less than one day
19	9	8	hrs. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual occupation Marine Corps

11. Industry or business

FATHER
12. Name Frank Bernard Bennett
13. Birthplace Pa.

MOTHER
14. Maiden name unknown
15. Birthplace unknown

16. Informant (father) Frank B. Bennett
Address 2965 Cochran Street, Duboistown, Penn.

17. burial (Burial, cremation, or removal. Which?) Date thereof 4-10-45 (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. Chambers,

Address 1400 Chapin St., N.W., Wash., D.C.

19. April 6 1945 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 6 1945, at 6:15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam Case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Fractured skull, brain injury	
Due to with hemorrhage	
Due to Shock	
Other conditions Homicide--Altercation in 400 block of Kennedy St. N. W.,	

(Include pregnancy within 3 months of death)

Major findings of operations April 6, 1945 Date of op.

Autopsy results Autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Bernhart M.D.
Dep. Med. Examr. M. D. or other

Address Gaithersburg Md. Date signed 4-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Released to District Authorities this date 4-6-45.

Frank J. Beuschart

Frank J. Beuschart, M.D.
Deputy Medical Examiner
For Montgomery County, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

03021

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 months

Hospital, institution, or street address where death occurred:

929 First ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 929 First ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Grace Blocher

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife Charles L. Blocher

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 28 1866

8. AGE: Years	Months	Days	If less than one day
79	1	22	....hrs. ....min.

9. Birthplace Hanover, Penna.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name Jacob W. Bender

13. Birthplace Adams Co. PA

MOTHER

14. Maiden name Sarah Slagle

15. Birthplace Adams Co. PA.

16. Informant Mrs. P. B. Blocher

Address 929 First ave Silver Spring, md.

17. Removal for Burial Date thereof March 25-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Carmel Cemetery

Location Littlestown, PA.

18. Funeral director John W. Little & Son

Address Littlestown PA Ry R. A. Little

19. March 23 1945 Josephine M. Schaffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945 at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 1945 to March 22 1945 and that I last saw her alive on March 22 1945

Immediate cause of death	DURATION
Gastric Hemorrhage	1 day
Cause Due to Undetermined.	
No further information can be obtained.	
Due to	
Other conditions General Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Marion Bankhead M.D.
M. D. or other

Address 9601 Sutton Place Silver Spring, md. Date signed 3/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52)

CERTIFICATE OF DEATH

03022

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Wheaton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Wheaton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11055 - Old Bladensburg Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MAHALATH FRANCES BROWN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Colored	Widowed.

6.(b) Name of husband ~~or wife~~ Benj. Brown.
Yes
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
69?			..... hrs. ..... min.

9. Birthplace Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden name Pumalia Jackson
15. Birthplace Va.

16. Informant Mrs Luella Lee
Address Rockville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 - 24 - 45 (month) (day) (year)
Cemetery or crematory Shiloh Cemetery
Location Middlebrug Va.
18. Funeral director Robt L. McGuire
Address 1820 - 9th St N.W.

19. Mar 21 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1945 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 1945 to March 20 1945 and that I last saw h~~im~~er alive on March 19 1945

Immediate cause of death	DURATION
Coronary Occulsion	
Due to Chronic Myocarditis	1 year.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Calvin B. Le Compte M. D. or other
Address Wheaton Md Date signed 3/20/45

5204 Lambeth Rd. Chev

2769

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-3)

CERTIFICATE OF DEATH

03023

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 200 Jones Bridge Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Louise Buckley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: Joseph

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan-19, 1856

8. AGE: Years	Months	Days	If less than one day
89	1	17	hrs. min.

9. Birthplace: Washington D.C.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Christian Ziegler

13. Birthplace: Germany

MOTHER — 14. Maiden name: Caroline Smith

15. Birthplace: Germany

16. Informant: Hospital Record

Address

17. 3/9/45 (Burial, cremation, or removal, Which?) Date thereof 3/9/45 (month) (day) (year)

Cemetery or crematory

Location: Washington D.C.

18. Funeral director: Deal Funeral Home

Address: 418-Kan Av. NW

19. 3/9 19 45 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 19 45 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 5th 19 45, to March 8 19 45

and that I last saw h... alive on March 8 19 45

Immediate cause of death	DURATION
Respiratory Failure	
Due to: Hypertensive Cardio Renal Disease	
Due to:	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank Jogger M.D.

M. D. or other

Address: 2016 Kenyon Rd Date signed 3/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

03024

CERTIFICATE OF DEATH

Reg. Dist. No. 218

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5½ hours.

Hospital, Institution, or street address where death occurred: Gaithersburg

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Rural Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME — Burroughs

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Premature 6 hrs. baby

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 31, 1945

8. AGE: Years	Months	Days	If less than one day
0	0	0	5½ hrs. ..... min.

9. Birthplace: Gaithersburg, Montgomery, Md. (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER — 12. Name: Wm E. Burroughs.

FATHER — 13. Birthplace: Washington D.C.

MOTHER — 14. Maiden name: Elma Clara Whitzel

MOTHER — 15. Birthplace: Manassas, Va.

16. Informant: Mrs Elma C. Burroughs

Address: Gaithersburg.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/31/45 (month) (day) (year)

Cemetery or crematory: Forest Oak Cemetery

Location: Gaithersburg Md.

18. Funeral director: E. L. Gaither

Address: Gaithersburg Md.

19. March 31 19 45 Alvin L. Cooke

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 19 45, at 10:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 31 19 45, to Mar 31 19 45 and that I last saw it alive on Mar 31 19 45

Immediate cause of death	DURATION
Premature - 6 hrs.	5½ hrs.
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. Brinsfield Shirley M.D. M.D. or other

Address: Gaithersburg Md. Date signed: Mar 31, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

03025

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: SILVER SPRING

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

~~Hospital, institution~~, or street address where death occurred:

8029 EASTERN AVE

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland. County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8029 Eastern Ave apt. 208.

(If rural, give LOCATION)

2.(a) If veteran, name war: none.

3.(a) FULL NAME Pauline Bushong

3.(b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female.	white	widowed.

6.(b) Name of husband or wife: William.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 11 1873

8. AGE:

Years	Months	Days	If less than one day
71	9	5	..... hrs. ..... min.

9. Birthplace: La Crosse - Wisc (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER

12. Name: Unknown Wagner.

13. Birthplace: La Crosse - Wisc.

MOTHER

14. Maiden name: Unknown.

15. Birthplace: La Crosse - Wisc.

16. Informant: Mrs Fred. A. Bushong.

Address: 8029 Eastern Ave Silver Spring. Md.

17. Removal. (Burial, cremation, or removal. Which?) Date thereof: Mar. 15 1945. (mouth) (day) (year)

Cemetery or crematory .....

Location: La Crosse - Wisc

18. Funeral director: Warner & Pumphrey.

Address: 8434 Ga Ave - Silver Spring. md.

19. Mar. 16 1945 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March Feb 15 1945, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam. to Care, 19.....

and that I last saw h..... alive on ....., 19.....

Immediate cause of death	DURATION
Coronary occlusion	Died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. Dep. Med. Exam., M. D. or other

Address: Westminster. Md. Date signed: 3-15-45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-6)

CERTIFICATE OF DEATH

03026

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Rural Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Eighteen months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rural, Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Avenel
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Thomas Ewing Calhoun

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah Elizabeth Phillips
6.(c) If alive, give age: 72 years
7. Birth date of deceased (mo., day, yr.): April 11, 1867

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
77	10	22		

9. Birthplace: Obion Co., Tenn. (Town, county, and state)
10. Usual occupation: Minister
11. Industry or business: Methodist Church
FATHER 12. Name: Joe B. Calhoun
FATHER 13. Birthplace: —
MOTHER 14. Maiden name: Emma L. Wynn
MOTHER 15. Birthplace: Tennessee
16. Informant: Mrs. Sarah E. Calhoun
Address: Avenel, Silver Spring, Md.
17. (Burial, cremation, or removal. Which?) Burial Date thereof: Mar. 5, 1945 (month) (day) (year)
Cemetery or crematory: Rec. Wash. Memo. Cem. Rockville Md.
Location: Washington D.C.
18. Funeral director: Morton W. Hyson Co.
Address: 1300 - N. St. N.W. Wash. D.C.
19. Mar. 3 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 1945, at 12:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1945, to March 3 1945, and that I last saw h.. alive on March 3 1945.

	DURATION
Immediate cause of death: Carcinoma of Prostate	25 mo.
Due to: Metastatic involvement of brain, sternum,	25 mo.
Due to: and spine	
Other conditions: Nephritis, subacute	2 weeks
Partial Intestinal Obstruction	1 week

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wallace R. Mook M.D.
Address: 805 Carroll Ave., Takoma Park 12 Md. M. D. or other
Date signed: 3-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

03027

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montg Co,

City or town: Gaithersburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 9 Mo

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montg

City or town: Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Roberta Bee Caton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Thomas J Caton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 6th 1870

8. AGE: Years	Months	Days	If less than one day
1870 75	2	17	..... hrs. ..... min.

9. Birthplace: PrinceWilliams Co Va,

(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: " "

FATHER 12. Name: George Riley

13. Birthplace: Va,

MOTHER 14. Maiden name: Lucy E Mason

15. Birthplace: Va,

16. Informant: Methodist Home, H M Wilson

Address: Gaithersburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/25/45 (month) (day) (year)

Cemetery or crematory: Sudley Cemetery

Location: Near Gainsville Va,

18. Funeral director: Ernest C Gabtner

Address: Gaithersburg Md,

19. March 23 1945 (Date rec'd by registrar) Abner L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23rd 19 45 at 5.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March - 21 19 45 to March - 23 19 45 and that I last saw h alive on March - 22 - 19 45.

Immediate cause of death	DURATION
Acute heart failure	2½ days
Due to: Myocardial Degeneracy	1-3 yrs
Due to: Senility -	5 yrs -
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H C Miller M D. M. D. or other

Address: Gaithersburg Md. Date signed 3/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-D)

03028

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Sadie Fuller Clark

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 7, 1873

8. AGE: Years: 71 | Months: 8 | Days: | If less than one day: hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: House Keeper

11. Industry or business

FATHER
12. Name: George Clark
13. Birthplace: Maryland

MOTHER
14. Maiden name: Caroline Nelson
15. Birthplace: Maryland

16. Informant: Addie Hood (Cousin)
Address: Sandy Springs, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 23 1945 (month) (day) (year)

Cemetery or crematory: Sandy Springs
Location: Sandy Springs, Md.

18. Funeral director: Robert L. Snowden
Address: 246 N. Wash. St. Rockville

19. 5-23- 1945 Gertrude B. Lewis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 20 1945, at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute Myocarditis	1/2 hr.
Due to: Chronic Interstitial Nephritis	3 yrs.
Due to:	
Other conditions: Chronic arthritis	22 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockhaus M.D.
Dep. Med. Exam. M. D. or other
Address: Gaithersburg, Md. Date signed: 3-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-M)

03029

CERTIFICATE OF DEATH

Reg. Diat. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Montg. Kensington Md.

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Kensington, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Clarksville, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William Norman Clarke

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Divorced

6.(b) Name of husband or wife: Catherine W.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 26, 1891

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
54				

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Operator of Riding Academy

11. Industry or business

FATHER — 12. Name: James Thomas Clarke

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Ella Hardey

MOTHER — 15. Birthplace: Md

16. Informant: John W. Clarke

Address: 2224 40th St. N. W.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: 3/31/45 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cem.

Location: Maryland

18. Funeral director: Wm Reuben Pumphrey

Address: 7557 Wis. Ave. Bethesda

18. 3-31-45 19..... (Date rec'd by registrar) William Mackey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 27 19 45, at Suburban M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam Case 19..... to 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia (Suicide)	Immed.
Due to Carbon monoxide	Undet.
Due to Poisoning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 3-27-45

Where did injury occur? Kensington (City or town) Montg. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Farm

Means of injury Injured at work?

23. SIGNATURE: Frank J. Bouchart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md. Date signed 3-29-45

1945
1951
324

Registration Dist. No. 2114

STATE OF MARYLAND—CERTIFICATE OF DEATH

Social Security No. 578-24-3101

1. PLACE OF DEATH

County Montgomery (740) Registration Dist. No.

Village or City Silver Spring No. 8411 Dixon Avenue St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Harold W Corton If U. S. Veteran, specify WAR World War #1

(a) Residence: No. 8411 Dixon Avenue St., Silver Spring, Md.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
male	white	married

5a. If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Vida Reduvine Corton

6. DATE OF BIRTH (month, day, and year) Sept. 25, 1894

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
50	5	20	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Government

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Clerk

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) Apopka (State or country) Florida

FATHER

13. NAME Robert Wesley Corton

14. BIRTHPLACE (city or town) — (State or country) Texas

MOTHER

15. MAIDEN NAME Minnie Belle Thompson

16. BIRTHPLACE (city or town) — (State or country) Georgia

17. INFORMANT Vida Reduvine Corton (Address) 8411 Dixon Ave., Silver Spring Md

18. BURIAL, ~~CREMATION, OR~~ REMOVAL Place Apopka Cemetery Date March 16, 1945 Apopka, Florida

19. UNDERTAKER Warner E. Pumphrey (Address) Silver Spring, Md.

20. FILED Mar. 15, 1945 Josephine M. Schaffe Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March (Month) 15 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May, 1942, to March 15, 1945

I last saw him alive on March 10, 1945; death is said to have occurred on the date stated above, at 3:30 A.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	3 days
Previous Coronary	1943

Other **Contributory Causes** of importance:

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy? —

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury ..., 19...

Where did injury occur? — (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury —

Nature of Injury —

24. Was disease or injury in any way related to occupation of deceased? —

If so, specify ...

(Signed) W. Bill Gardner M. D.

(Address) 943 Bonifant St. Silver Spring Md

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at **school** or at **home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

03031

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:
County Montgomery
City or town Rural Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, institution, or street address where death occurred:
Rockville Pike - Rockville
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Spring Lake Pk - Rural Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Wabel Street
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Emoly Floyd Cunningham

3.(b) Social Security Number 577-22-2256

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Josephine Cunningham 6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) March 24 - 1890

8. AGE: Years	Months	Days	If less than one day
54	11	20	hrs. min.

9. Birthplace Loudon Co - Virginia (Town, county, and state)
10. Usual occupation Gardner - Handyman
11. Industry or business

FATHER 12. Name	Frank Cunningham
FATHER 13. Birthplace	Loudon Co - Va
MOTHER 14. Maiden name	Jenny Mills
MOTHER 15. Birthplace	Virginia

16. Informant Miss Gladys Frances
Address R F D # Rockville - Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 19-1945 (month) (day) (year)
Cemetery or crematory Mt. View Church Cem
Location Bethesda - Maryland
18. Funeral director Wm. Reuben Dougherty
Address Rockville - Maryland
19. 3/18/45 (Date rec'd by registrar) Josephine D Hatton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945 at 12:15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam 19 to case 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Bouchat M. D.
M. D. or other
Address Dep. Med. Exam. Gaithersburg Md Date signed 3-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

03032

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 5105 Custer Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5105 Custer Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: WILLIAM EARL DALRYMPLE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married.

6.(b) Name of husband or wife: Helen
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): April 1 - 1891

8. AGE: Years: 53 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: U.S. Gov. War Dept.

11. Industry or business:

FATHER
12. Name: Ellis Dalrymple
13. Birthplace: Ohio

MOTHER
14. Maiden name: Annie White
15. Birthplace: Ohio

16. Informant: Robert C. Dalrymple
Address: 5408 Harwood Rd. Wash. D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 3/9/45 (month) (day) (year)
Cemetery or crematory: Arlington Nat'l Cem.
Location: Arlington, Va.

18. Funeral director: The J. H. Smith Co.
Address: 2901 - 14 - N.W.

19. 3/9 1945 (Date rec'd by registrar) Wm. E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 9 1945, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1939, to Mar. 9 1945
and that I last saw him alive on Mar. 9 1945

Immediate cause of death	DURATION
Coronary Occlusion	1 day
Due to: Hypertension	
Due to: Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

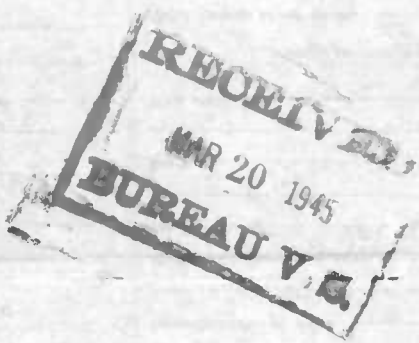
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Karl Engelbach M.D.
M. D. or other
Address: 3120 Wis. Ave. Date signed: 3/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
MAR 20 1945
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

03033

CERTIFICATE OF DEATH

Reg. Diat. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Montgomery

City or town Sellman

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life 78 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montg

City or town Sellman

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas Franklin Dawne

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Isabel Dawne

6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Aug 10 - 1866

8. AGE: Years 78 | Months 7 | Days 12 | If less than one day ... hrs. ... min.

9. Birthplace Montg Co. Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Alexandria Dawne

13. Birthplace Virginia

MOTHER 14. Maiden name Catherine Hall

15. Birthplace Maryland

16. Informant W. T. Dawne

Address Sellman, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/24/45 (month) (day) (year)

Cemetery or crematory Monocacy

Location Barnesville, Md

18. Funeral director William B. Hilton

Address Barnesville, Md

19. 3/23/ 1945 (Date rec'd by registrar) Mrs. C.C. Hilton by Mrs. W.B.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 - 1945, at 6.45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14 - 1943 to March 22 - 1945 and that I last saw him alive on March 22 - 1945

Immediate cause of death	DURATION
Cardio-renal - Vascular Disease	5 yrs +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Byron D. White, Md. M. D. or other

Address Barnesville, Md Date signed 3/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03034

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town) R.D. #2

How long in above place of death? Since Mar. 14-'45.

Hospital, Institution, or street address where death occurred: Sedarco Sanitarium

How long in hospital or institution? Since Mar. 14-45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 2804-14 St. nw (If rural, give LOCATION)

2.(a) If veteran, name war: ✓ none ✓

3. (a) FULL NAME: Ray Davis

3. (b) Social Security Number: - ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Divorced

6.(b) Name of husband or wife: Lillian Marriotte

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 19- 1894

8. AGE: Years: 51 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Alex., Va. (Town, county, and state)

10. Usual occupation: Newspaper

11. Industry or business:

FATHER
12. Name: ?
13. Birthplace:

MOTHER
14. Maiden name: Ella Fairfax
15. Birthplace: Alex. Va.

16. Informant: Gerald Davis Son

Address: 2804-14 St. nw D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 26, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Alexandria Va.

18. Funeral director: J. S. Eveily

Address: Alexandria Va

19. Mar. 26 1945 Josephine M Schaeffer
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 25 1945, at 6.15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar. 14 1945, to Mar. 25 1945, and that I last saw h.. alive on Mar. 25 1945

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to	
Due to	
Other conditions: Arteriosclerosis	?
Hypertension (include pregnancy within 3 months of death)	?

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Richard B. Thibadeau M.D.
M. D. or other

Address: Box 271 Silver Spring Md. Date signed: 3/25-'45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

03035

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County Montg.
City or town Gaithersburg Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
Montg. Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montg.
City or town Gaithersburg Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Montg. Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Douglas O Dash.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married.

6.(b) Name of husband or wife Laura W. Bohrer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1905

8. AGE: Years	Months	Days	If less than one day
39	4	15	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Bookeeper
11. Industry or business
12. FATHER Name W. D. Dash
13. Birthplace Maryland
14. MOTHER Maiden name Caroline Smith
15. Birthplace Maryland
16. Informant Mrs. Cyril Clark.
Address Sister In Law

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/10/45 (month) (day) (year)
Cemetery or crematory Forest Oak Cemetery
Location Gaithersburg Md.
18. Funeral director Wm Reuben Cramphrey
Address 7557 Wis. Ave. Bethesda
19. March 9 1945 (Date rec'd by registrar) Alvida G Clarke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8th 1945 at 10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1944 to March 8th 1945 and that I last saw h im alive on March 7th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 mo.
Due to —	
Due to —	
Other conditions Chronic Arthritis	3 yrs.
Diabetes Mellitus	10 yrs.

(Includo pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Walter D Howard M.D
M. D. or other
Address Damsonville Md Date signed 3/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

03036

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Friendship Heights, Ch. Ch., Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Friendship Heights, Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 325 High Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Leila M. Dulin

3.(b) Social Securily Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James C. Dulin, Jr.
6.(c) If alive, give age: 53 years
7. Birth date of deceased (mo., day, yr.): December 4th. 1890

8. AGE: Years	Months	Days	If less than one day
54	3		....hrs. ....min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: John William Bogley
13. Birthplace: Montgomery County, Md.
MOTHER 14. Maiden name: Ann Rebecca Fletcher
15. Birthplace: Washington, D. C.
16. Informant: James C. Dulin, Jr.
Address: 325 High St., Friendship Hgts., Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 7th. 1945 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Washington, D. C.
18. Funeral director: Joseph F. Burke Son
Address: 3064 M St., N.W., Washington, D. C.
19. 3-5 1945 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7:30 A.M. March 4th 1945 at ....M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15th 44 19.... to 3-4-45 19....
and that I last saw h.. alive on 3-3-45 19....

Immediate cause of death	DURATION
Exhaustion, dyspnea, hemorrhage, internal	5 days to 3 months
Due to: Carcinoma of uterus; ureters, adnexa, liver, intestines	At least a year
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Carcinoma of uterus + adnexa + intestines Date of op. July + Dec. 44
Autopsy results: Not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. P. Moulden M.D.
M. D. or other
Address: 3401 Dowell St. N.W. Date signed: 3-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

03037

CERTIFICATE OF DEATH

Reg. Diat. No. 2 16

1. PLACE OF DEATH

County: Montgomery

City or town: Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 hrs - Plus 40 min

Hospital, institution, or street address where death occurred: Suburban Hospital Assn. Inc.

How long in hospital or institution? 24 hrs - 40 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Columbia County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1911 R. Street N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Ella D. Esmond

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

6.(b) Name of husband or wife: William H. Esmond

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 16, 1882

8. AGE: Years	Months	Days	If less than one day
63	—	18	hrs. min.

9. Birthplace: Connecticut, U.S.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER

12. Name: Danger

13. Birthplace: Germany

MOTHER

14. Maiden name: Eisenjan

15. Birthplace: West Point, N.Y.

16. Informant: Hospital Records - P. Goodall

Address: 36th and Georgetown D. Kathenda

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 9, 1945 (month) (day) (year)

Cemetery or crematory: Bridgeport, Conn.

Location:

18. Funeral director: Martin W. Hysong Co.

Address: 1300 - N 80 - N.W. Washington D.C.

19. 3/6/1945 (Date rec'd by registrar) Wm E. Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 March 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Dec 1944, 19, to 6 March 1945, 19; and that I last saw h.r alive on 6 March 1945.

Immediate cause of death	DURATION
Pneumonia	
Due to: bronchial	
Due to:	
Other conditions: Arteriosclerosis	
Heart Disease	

(Include pregnancy within 3 months of death)

Major findings of operations: None.

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Charles L. Hallen M.D.

M. D. or other

Address: 1801 Eye St N.W. Date signed: 6 March 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

03038

CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, Institution, or~~ street address where death occurred: 1311 Maple St, Linden, Silver Spring

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1311 Maple St. (Linden)

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Marshall Ashby Gibbs

3.(b) Social Security Number: 577-07-7577

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Katherine S.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Mar 17th 1902

8. AGE: Years	Months	Days	If less than one day
42	11	29	..... hrs. ..... min.

9. Birthplace: Summerset - Md

(Town, county, and state)

10. Usual occupation: Analyst

11. Industry or business: War Production Board

FATHER

12. Name: Edwin Hayden Gibbs

13. Birthplace: Wash DC

MOTHER

14. Maiden name: Georgia Totten Raub

15. Birthplace: Wash. DC

16. Informant: Mrs Katherine S Gibbs (wife)

Address: 1311 Maple St. Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 19 1945 (month) (day) (year)

Cemetery or ~~crematory~~: Fort Lincoln

Location: Prince Georges Co. Md.

18. Funeral director: Wood E Pumphrey

Address: 8035 Ga Ave. Silver Spring - Md

19. Mar 19 1945 (Date rec'd by registrar) Josephine McSchaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 16 1945, at 6:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sep Med Exam case 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. Dep. Med. Exam M. D. or other

Address: Gaithersburg Md Date signed: 3-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03039

CERTIFICATE OF DEATH

Reg. Dist. No. 7 16

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda 14, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hosp
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Washington (If outside city or town limits, write RURAL and give nearest town)
Street No. 3729 Cumberland St NW (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs Nannie Geddes
3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: deceased
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Oct. 20, 1870
8. AGE: Years 74 Months 5 Days 2 If less than one day ... hrs. ... min.
9. Birthplace: Berkley Spgs West Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: James Hunter
13. Birthplace: West Virginia
MOTHER 14. Maiden name: Louise Green
15. Birthplace: West Virginia
16. Informant: Hospital Records, [illegible] Goodall
Address: 8600 Old Georgetown Rd. Bethesda
17. Removal (Burial, cremation, or removal. Which?) Date thereof 3/22/45 (month) (day) (year)
Cemetery or crematory
Location: Wash. D.C.
18. Funeral director: H. M. Chambers Co
Address: 517 - 11 - St. S.E.
19. 3/22 19 45 Wm E Jobes (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945, at 1:22 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Carcinoma of breast with (?) generalized metastasis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Arch L. Riddick M.D. (M. D. or other)
Address 1835 Eye St N.W. Wash D.C. Date signed 3-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

03040

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Monty.

City or town: Bethesda Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

4524 Gladewyne Dr.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monteg.

City or town: Bethesda Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4524 Gladewyne Dr.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Emily Loudon Loudon Nagel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

B.(b) Name of husband or wife: Frederick E.

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 8, 1884

8. AGE: Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace: Keswick Va (Town, county, and state)

10. Usual occupation: Chief Sub. Voucher Sec. U.S. Coast Guard

11. Industry or business

FATHER 12. Name: Andrew Jackson

13. Birthplace: Va

MOTHER 14. Maiden name: Anna Bland

15. Birthplace: Va.

18. Informant: Fred. E. Nagel

Address: 4524 Gladewyne Dr.

17. (Burial, cremation, or removal. Which?) Cremation Date thereof: 3/16/45 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Maryland

18. Funeral director: W. Reuben Trumphrey

Address: 7557 Wis. Ave. Bethesda

19. 3/16 19 45 Wm E Jobe MD

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/13/45 19 at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 27 1944, to Mar. 13 1945 and that I last saw h[illegible] alive on March 12 1945

Immediate cause of death: Coronary Thrombosis

Heart Failure — DURATION: 3 days

Due to: Partial Occlusion of Lumen — 2 yrs.

Due to:

Other conditions: Diabetes Mellitus — 5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Coronary Occlusion

Date of op. 1/26/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frederick E. Loudon M. D. or other

Address: 7921 Eastern Ave. Silver Spring Md. Date signed: 3/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-a

03041

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution? 28 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Highland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Gertrude Harding

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife John Harding

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 18, 1878

8. AGE: Years	Months	Days	If less than one day
66	8	17	..... hrs. ..... min.

9. Birthplace Dayton, Howard County, Maryland (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business —

FATHER 12. Name Bowie Johnson

13. Birthplace Dayton, Maryland.

MOTHER 14. Maiden name Louise Thompson

15. Birthplace Dayton, Maryland.

16. Informant Hospital records.

Address

17. Burial (Burial, cremation, or removal, which?) Date thereof May 7 1945 (month) (day) (year)

Cemetery or crematory Mt. Zion Cemetery

Location Highland Md.

18. Funeral director J. C. Higginbotham

Address Ellicott City, Md.

19. 3-6-1945 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1945, at 1 20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 - 1945, to March 5 1945

and that I last saw h.e. alive on March 5 1945

Immediate cause of death	DURATION
acute myocarditis	2 days
Due to chronic ulcerative co-	
Due to colitis	6 mos
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas E Tumbleson M. D. or other

Address Sandy Spring, Md Date signed 3/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

03042

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

Reg. Diat. No. 214

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Montgomery
City or town: Fairland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution? Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Fairland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. Silver Spring, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HARRY G. HARDING

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife: Bertha D. Harding
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 24, 1873

8. AGE: Years	Months	Days	If less than one day
71	6	7	..... hrs. ..... min.

9. Birthplace: MARYLAND.
(Town, county, and state)
10. Usual occupation: FARMER.
11. Industry or business

FATHER
12. Name: JACKSON HARDING
13. Birthplace: Md.

MOTHER
14. Maiden name: Margaret Myers
15. Birthplace: Unknown, Md.

16. Informant: MRS. BERTHA D. HARDING
Address: FAIRLAND, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 6, 1945 (month) (day) (year)
Cemetery or crematory: Union Cemetery
Location: Burtonsville, Md.

18. Funeral director: J. Arthur Waldeck
Address: 254 Carroll St., Takoma Park, D.C.

19. Mar. 3 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 3 - 1945 - 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 - 1945, to Mar. 2, 1945 and that I last saw him alive on Mar. 2nd - 1945.

Immediate cause of death	DURATION
Hemiplegia	3 days
Due to: Hypertension	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Chas E. Tumbleson M. D. or other
Address: Sandy Spring, Md. Date signed: 3-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

03943

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County Money
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
#7 Williams Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Money
City or town #7 Chevy Chase Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. #7 Williams Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME David J. Higgins

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Katherine T.
6.(c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) Aug. 24, 1872

8. AGE: Years	Months	Days	If less than one day
72			hrs. min.

9. Birthplace Silver Lake, N.Y. (Town, county, and state)
10. Usual occupation Engineer.
11. Industry or business

FATHER
12. Name John Higgins
13. Birthplace Ireland

MOTHER
14. Maiden name Margaret Milcahy
15. Birthplace Ireland

16. Informant Mrs. Brant
Address Bethesda, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/3/45 (month) (day) (year)
Cemetery or crematory Mt. Olivet Cem.
Location Wash. D.C.
18. Funeral director Wm Reuben Tumphrey
Address 7557 Wis. Ave. Bethesda
19. 4/1 19 45 (Date rec'd by registrar) Wm E Jobe M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 31 19 45 at 7:15 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dep. Med. Exam. 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	about 1 min. suddenly
Due to	
Due to	
Other conditions Hypertension	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Brandt M.D. Dep. Med. Exam. M. D. or other
Address Gaithersburg, Md. Date signed 3-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03044

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Montgomery County General Hospital

How long in hospital or institution? 15 Days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Sandy Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Josephine Hill

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 11, 1942

8. AGE: Years	Months	Days	If less than one day
2	6	12	hrs. min.

9. Birthplace Olney, Montgomery Co. Md.
(Town, county, and state)

10. Usual occupation Child.

11. Industry or business

FATHER
12. Name James Hill
13. Birthplace Ashton - Md.

MOTHER
14. Maiden name Alice Bell
15. Birthplace Norristown - Pa.

18. Informant Hospital Records
Address Olney, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 25, 1945 (month) (day) (year)

Cemetery or crematory Sandy Spring

Location Sandy Spring, Md.

18. Funeral director Robert L. Snowden

Address 246 N. Wash. St. Rockville

19. 3-24-1945 (Date rec'd by registrar) Garland B. Farrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1945 at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 21 - 1945 to Mar 23 - 1945 and that I last saw h.. alive on Mar 23 - 45 - 1945

Immediate cause of death	DURATION
Lobar pneumonia	9 days
Due to Pulmonary tuberculosis, Cav. (R.	
See Dr. Ellicott's letter, July 5, 1945	
Due to	
Other conditions Streptococcus throat + bilateral otitis media	3 wks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas L. Tumbleson M. D. or other

Address Sandy Spring, Md. Date signed 3-24-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

03045

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town "Belmont" Ednor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital, institution, or~~ street address where death occurred: "Belmont"
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Ednor
(If outside city or town limits, write RURAL and give nearest town)
Street No. "Belmont"
(If rural, give LOCATION)
2.(a) If veteran, name war none

3. (a) FULL NAME INEZ S. HOPKINS

3. (b) Social Security Number none

4. Sex female
5. Color or race white
6.(a) Single, married, widowed, or divorced widowed
6.(b) Name of husband or wife Rev. A S M
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Jan 23rd. 1855

8. AGE: Years	Months	Days	If less than one day
90	2	6	... hrs. ... min.

9. Birthplace Edenboro, Pa (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business —
FATHER 12. Name Wm Van Dyke
13. Birthplace Pa
MOTHER 14. Maiden name Unknown Tower
15. Birthplace Pa.
16. Informant Mrs Arthur C Christie
Address Belmont - Ednor. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 18, 1945 (month) (day) (year)
Cemetery or crematory Cranesville
Location Cranesville, Erie Co. Pa
18. Funeral director Warner E Pumphrey
Address 8434 Ga Ave - S
19. Apr. 17 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27/ 1945, at 7 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/15/ 1945, to 3/29/ 1945 and that I last saw her alive on 3/27/ 1945

	DURATION
Immediate cause of death Uremia	6 days
Due to General arterio sclerosis	2
Due to Herpes Zoster	6 wks
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address Sandy Spring Md Date signed 3/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

03046

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital Inc.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland, County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Henry J. Kelly

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 10, 1917

8. AGE: Years 28 | Months | Days | If less than one day hrs. min.

9. Birthplace Silver Spring, Montg. Co. Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Matthew Kelly
13. Birthplace - - - - - -

MOTHER
14. Maiden name Eleanor
15. Birthplace - - - - - -

16. Informant Hospital record
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 8, 1945 (month) (day) (year)

Cemetery or crematory Good Hope Cemetery

Location Good Hope, Md.

18. Funeral director R. L. Snyder

Address 246 N. Washington St. Rockville, Md.

19. 3-6- 1945 Gertrude B. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1945 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1945 to March 5 1945 and that I last saw him alive on March 5 1945.

	DURATION
Immediate cause of death Acute cardiac dilatation	1 da.
Due to Chronic Myocarditis	30 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md Date signed 3/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2) X

CERTIFICATE OF DEATH

03047

Reg. Dist. No. 223

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 days
Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 243 Farragut St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Therese KarsKa-KuKacKa

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~ Joseph KarsKa KuKacKa
6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Mar. 27 - 1872

8. AGE: Years	Months	Days	If less than one day
72	11	17	..... hrs. ..... min.

9. Birthplace Nevdorf, Czechoslovakia (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Jacob StraKa
13. Birthplace Czechoslovakia

MOTHER
14. Maiden name Therese HovorKa
15. Birthplace Czechoslovakia

16. Informant Husband of deceased
Address 243 Farragut St. N.W. Wash. D.C.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Mar 17 1945. (month) (day) (year)
Cemetery or crematory Cedar Hill Crematory
Location
18. Funeral director Arthur Walters
Address 2 Harold St. Takoma Park, D.C.

19. Mar 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 13- 1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 9, 1945 to Mar. 13- 1945 and that I last saw her alive on Mar. 13- 1945

	DURATION
Immediate cause of death Carcinoma of colon	5 mo.?
Due to Generalized metastasis of carcinoma	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Carcinoma colon, omentum, bronchi
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wallace W. Mook M.D. M. D. or other
Address 805 Carroll Ave., Takoma Park, Md Date signed 3-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

03048

CERTIFICATE OF DEATH

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? died enroute

Hospital, Institution, or street address where death occurred:
died enroute to US Naval Hosp., Bethesda, Md.

How long in hospital or institution? died enroute

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County: Arlington

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4302 So. 36th Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: LANDERS, Barbara Holman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Albert Cole LANDERS

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 21 May 1920

8. AGE:

Years	Months	Days	If less than one day
24	10	1	____ hrs. ____ min.

9. Birthplace: Boston, Mass.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: William J. Holman
13. Birthplace: unknown

MOTHER
14. Maiden name: Ruth Burke
15. Birthplace: unknown

16. Informant: husband: Albert C. LANDERS, Lt.(SC) USNR
Address: 4302 S. 36th St., Arlington, Va.

17. removal (Burial, cremation, or removal. Which?) Date thereof 3-22-45 (month) (day) (year)

Cemetery or crematory: [illegible]

Location: [illegible]

18. Funeral director: S. H. HINES

Address: 2901 14th St., N. W., Wash. D. C.

19. 3-22-45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 22 1945, at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sep. Med. Exam Case 19__ to 19__

and that I last saw h__ alive on 19__

Immediate cause of death	DURATION
Cerebral embolism	2 hrs.
Due to: Nephritis	
Due to:	
Other conditions	

(Include pregnency within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Frank J. Broschart M. D. Dep. Med. Examiner M. D. or other

Address: Hagerstown, Md. Date signed 3-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

03649

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
3 Kenilworth Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3 Kenilworth Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Lamming

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Nellie E. Lamming
6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) July 5, 1878

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
74	4	22		

9. Birthplace Knoxville, Tennessee
(Town, county, and state)
10. Usual occupation Real Estate
11. Industry or business

FATHER
12. Name Orval Lamming
13. Birthplace Tennessee

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mrs. Edward Yardley
Address 3 Kenilworth Dr.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/17/45 (month) (day) (year)
Cemetery or crematory Glenwood Cem.
Location D.C.

18. Funeral director Wm Reuben Humphreys
Address 7557 Wis. Ave. Bethesda

19. 3/16 (Date rec'd by registrar) 19 45 Wm E Jolley MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14 19 45, at 11 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 45 to 3-13 19 45 and that I last saw h. im alive on 3-13 19 45

	DURATION
Immediate cause of death: Coronary Heart Disease	May 1939 - March 1945
Due to: Generalized Arteriosclerosis with Cardio Renal disease	10 yrs
Due to:	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE S. Arthur Kark MD M. D. or other
Address Wash. Sanitarium Hospital Date signed 3/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH 03050

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (107)

County Montgomery County — Registration Dist. No. 213.

Village or City Rockville, Md. — No. 500 W. Montgomery Ave. — St., — Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 6 yrs. 4 mos. ds. — How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Miss Laura Lacey Leggett — If U. S. Veteran, specify WAR

(a) Residence: No. Sandy Spring, Md. — St., — Ward.
(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) Jan. 1, 1865

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	80	2	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) New York
(State or country) New York

FATHER

13. NAME Francis W. Leggett

14. BIRTHPLACE (city or town) New York
(State or country) New York

MOTHER

15. MAIDEN NAME Laura Lacey Acker

16. BIRTHPLACE (city or town) Kalamazoo
(State or country) Michigan

17. INFORMANT Mrs. Milton H. Bancroft
(Address) Sandy Spring, Md.

18. ~~BURIAL~~, CREMATION, OR REMOVAL
Place Cedar Hill - md Date Mar 22, 1945

19. UNDERTAKER Wm. Pretzel Pumphrey
(Address) Rockville - Maryland

20. FILED 3/21, 1945 Josephine D. Wootton
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH
March (Month) 19 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1938, to March 19, 1945

I last saw her alive on March 19, 1945; death is said to have occurred on the date stated above, at 7:35 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Pneumonia-broncho	3/5/45
Other Contributory Causes of Importance:	
Arteriosclerosis, General	?

Name of operation — Date of

What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of Injury, 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Dewitt M. Bullard M. D.

(Address) Rockville, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03951

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Telephone

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henry Magruder

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	married

6.(b) Name of husband or wife: Bessie

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 6, 1890

8. AGE:

Years	Months	Days	If less than one day
54	11	16	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmwork

11. Industry or business

FATHER

12. Name: Ned Magruder

13. Birthplace: Maryland

MOTHER

14. Maiden name: - - - - - - - - -

15. Birthplace: Maryland

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 24, 1945 (month) (day) (year)

Cemetery or crematory: Lincoln Park

Location: Rockville, Maryland

18. Funeral director: Robert H. Snowden

Address: 246-N. Kash. St. Rockville, Md

19. 3/24 19 45 (Date rec'd by registrar) M E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-21 19 45 at 6:20 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-15 19 45 to 3-21 19 45 and that I last saw h... alive on March 21 19 45

	DURATION
Immediate cause of death: Cerebral thrombosis	10 days
Due to: Aortic aortitis	?
Due to: Syphilis	?
Other conditions: Paralysis of all 4 extremities (Include pregnancy within 3 months of death)	10 days

Major findings of operations

Date of op.

Autopsy results: not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James Hagan M.D. M. D. or other

Address: 1801 Eye St N.W. Date signed: 3-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03652

CERTIFICATE OF DEATH

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos - 13 days.

Hospital, Institution, or street address where death occurred:

Suburban Hosp

How long in hospital or institution? 2 mos x 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. R. #2

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3. (a) FULL NAME: Mary L. Magruder

3. (b) Social Security Number: .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 15, 1903

8. AGE: Years 40 | Months 7 | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace: Montgomery County, Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: .....

FATHER — 12. Name: Henry Magruder

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Janie Handy

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: 8600 Old Georgetown Rd Bethesda

17. Buried (Burial, cremation, or removal. Which?) Date thereof March 19, 1945 (month) (day) (year)

Cemetery or crematory: St Mary Cemetery

Location: Rockville, Md

18. Funeral director: R. L. Saunders

Address: 246 N. Wash. St Rockville Md

19. 3/18/45 (Date rec'd by registrar) Wm E Dobbs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 14, 1945, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Immediate cause of death: Toxemia + Cachexia	
Due to: Multiple trophic ulcers of feet + extremities	
Due to: Acute angulation of thoracic spine with compression of	
Other conditions: Renal Ind.	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: See above - 3-14-45

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Richard E. Kelso, M.D.

M. D. or other

Address: Suburban Hospital Date signed 3-14-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

03653

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town 2317 Michigan Ave.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring Prince Geo.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2317 Michigan Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lucy Mc Cubbins.

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife
8.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) December 11, 1882

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace Charles County, Md.
(Town, county, and state)
10. Usual occupation House Keeper
11. Industry or business

FATHER
12. Name Dentist Marshall
13. Birthplace Charles County, Md.

MOTHER
14. Maiden name Melvina C Bateman
15. Birthplace Charles County, Md.

16. Informant Mrs. Carrie Dunn (daughter)
Address 210 L St S.W. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 5, 1945 (month) (day) (year)
Cemetery or crematory Mt Zion
Location Silver Spring, Md.

18. Funeral director Robert L. Saunders
Address 246 Rockville, Md.

19. Mar. 3 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2 1945, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1944 to 3-2 1945 and that I last saw h[illegible] alive on 2/28 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to Coronary Disease	6 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Calvin B. LeCompte M. D. or other
Address Wheaton Md Date signed 3/4/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of name of town of death is shown on FILM No. G 9 4 MAY 15 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (562)

CERTIFICATE OF DEATH

03654

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Montg Co
City or town: Takoma Park
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 7 Yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montg Co
City or town: Takoma Park Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 403 chestnut Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John E. McIntyre

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12-11- 1923

8. AGE:

Years	Months	Days	If less than one day
21	3	6	hrs. min.

9. Birthplace: Dc (Town, county, and state)
10. Usual occupation: Student
11. Industry or business

FATHER
12. Name: Wm E McIntire
13. Birthplace: Dc

MOTHER
14. Maiden name: Mildred Ketchmore
15. Birthplace: Va

16. Informant: Mr Wm E McIntire
Address: 403 chestnut ave

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3-17-45 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Washington Dc

18. Funeral director: Huntemann Funeral Home
Address: 5202 Ga Ave

19. Mar 17th 1945 (Date rec'd by registrar) J. Holmes Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 17 1945, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 17, 1945, to ——, 19—, and that I last saw him alive on Mar. 17, 1945.

Immediate cause of death	DURATION
Progressive Muscular Dystrophy	14 yrs.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. B. Sutton, M.D. M. D. or other
Address: 6911 Sligo Rd. Md. Washington D.C. Date signed 3/17/45

This case had not been recently under medical care. I saw him in emergency today, only. Cause of death is as stated on reverse side and is perfectly legal.

[illegible] M.D.

RECEIVED
APR 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-2

03655

CERTIFICATE OF DEATH

Reg. Dist. No. 716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montg.

City or town: Chevy Chase — (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred: 607 East Thornapple St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Chevy Chase Md (If outside city or town limits, write RURAL and give nearest town)

Street No. 607 East Thornapple St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Martha P. McLeod

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Don McLeod.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 28, 1869

8. AGE: Years	Months	Days	If less than one day
75			..... hrs. ..... min.

8. Birthplace: Mo. (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER — 12. Name: C. W. Carter

FATHER — 13. Birthplace: Mo.

MOTHER — 14. Maiden name: Nancy Dyer

MOTHER — 15. Birthplace: Mo.

18. Informant: Mrs. Nancy M. Robinson

Address: 607 East Thornapple St.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof: 3/4/45 (month) (day) (year)

Cemetery or crematory: Seymour Texas

Location: Seymour Texas

18. Funeral director: Wm Reuben Dunphrey

Address: 7557 Wis. Ave. Bethesda, Md.

19. 3/4 (Date rec'd by registrar) 19 45 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3, 19 45, at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20 19 45, to Mar. 3 19 45

and that I last saw h.. S.. alive on Mar. 3 19 45

	DURATION
Immediate cause of death: cerebral thrombosis	11 days
Due to: arteriosclerotic Heart Disease	5 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Harold Kenzer (Heiges), M.D. M. D. or other

Address: Mayflower Hotel Date signed 3/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-d)

03656

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Mont

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Mont

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 915 Heron Dr

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sandra Louise Mooney

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 31 194X

8. AGE: Years | Months: 2 | Days: 1 | If less than one day: ..... hrs. ..... min.

9. Birthplace: md (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Harold A Mooney

13. Birthplace: Wash DC

MOTHER — 14. Maiden name: Eleanor Lyles

15. Birthplace: Wash DC

16. Informant: Harold A Mooney

Address: 915 Heron Dr. Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 5, 1945 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Fort Lincoln, Washington, DC

18. Funeral director: J. Arthur Walters

Address: 254 Carroll St., N.W. City

19. Mar. 2 194X (Date rec'd by registrar) Josephine M. Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 2 194X at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 31 19.. to ..... 19.. and that I last saw h..... alive on ..... 19..

Immediate cause of death	DURATION
Asphyxia due to	Few hours
Due to Vomiting (Aspiration)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: see as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of 3-2-45

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J Brosnahan M.D. Dep. Med. Exam. M. D. or other

Address: Silver Spring Md Date signed 3-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

03057

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months & 7 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2 mons & 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1930 37th St., N. W., W
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MURPHY, John Joseph, Chief Quarter Master USN Retired Inactive

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Anna K. Murphy
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 30 May 1886

8. AGE: Years	Months	Days	If less than one day
58	9	1	hrs. min.

9. Birthplace: Mass.
(Town, county, and state)
10. Usual occupation: Navy
11. Industry or business:

FATHER
12. Name: James A. Murphy
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Ann Fitzpatrick
15. Birthplace: Ireland

16. Informant: Wife: Mrs. Anna K. Murphy
Address: 1930 37th St., N. W., Wash., D. C.

17. burial — Date thereof 3-5-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: Wm. R. Pumphrey Sons
Address: Wis., Avenue, Bethesda, Md.

19. 3-1- 45 — Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 March 1945 at 05:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 Dec. 1944 to 1 March 1945 and that I last saw him alive on 28 Feb. 1945

	DURATION
Immediate cause of death: Myocardial failure	30 min
Due to: Myocardial Infarction	30 min
Due to: Coronary Sclerosis	3-5 years
Other conditions: Cholecystitis, Cholelithiasis, Cholecystolithiasis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Cholecystitis Biliary calculi in common duct — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. W. Sager Comdr (MC) USNR
W. W. Sager, Comdr. (MC) USNR
M. D. or other
Address: US Naval Hospital, Bethesda, Md. Date signed: 3-1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03658

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Monty

City or town: Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs.

Hospital, Institution, or street address where death occurred:
7817 Georgetown Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Monty

City or town: Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7817 Georgetown Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Melville W. Murphy

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Mary C.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 8, 1883

8. AGE: Years	Months	Days	If less than one day
62			..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business

FATHER
12. Name: Wilber Murphy
13. Birthplace: unknown

MOTHER
14. Maiden name: Alice Louise
15. Birthplace: Wash. D.C.

16. Informant: Mary C. Murphy
Address: 7817 Georgetown Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/28/45 (month) (day) (year)

Cemetery or crematory: Glenwood Cem.

Location: Wash. D.C.

18. Funeral director: Wm Reuben Tumphrey

Address: 7557 Wis. Ave. Bethesda

19. 3/26 19 45 Wm E Johns Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24/45 19 ..... at 4 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 19 45 to March 19 45 and that I last saw h alive on March 23 19 45

Immediate cause of death	DURATION
Acute Dilatation of Heart	3 hrs
Due to Hypertension	7 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

28. SIGNATURE Lewis Towson M.D. M. D. or other

Address 5016 Dwight Rd. Date signed 3/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

CERTIFICATE OF DEATH

03659

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred:

9510 Woodley ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Silver Spring Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9510 Woodley Ave

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Charles Richard Nixon

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

B.(b) Name of ~~husband or~~ wife Mrs Grace K. Nixon

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Dec 29, 1873

8. AGE:

Years	Months	Days	If less than one day
71	2	9	...hrs. ...min.

9. Birthplace Port Hope, Ontario Canada (Town, county, and state)

10. Usual occupation Retired

11. Industry or business —

FATHER 12. Name Charles Richard Nixon

FATHER 13. Birthplace Ontario, Canada

MOTHER 14. Maiden name Jane Irish

MOTHER 15. Birthplace —

16. Informant Mrs H. S. Stephens

Address 9510 Woodley ave Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 12, 1945 (month) (day) (year)

Cemetery ~~or crematory~~ George Washington Memorial Park

Location Riggs Road, Md.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. Mar. 12 1945 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1945, at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1943 to March 9 1945

and that I last saw h...alive on Feb. 20 1945

Immediate cause of death Angina pectoris — DURATION 8 yrs.

Due to ... DURATION ...

Due to ... DURATION ...

Other conditions Cardio - Renal disease — DURATION ...

(Include pregnancy within 3 months of death)

Major findings of operations ...

Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE J. Marion Bankhead M.D. M. D. or other

Address Silver Spring, Md. Date signed 3/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03960

CERTIFICATE OF DEATH

Reg. Diat. No. 223

1. PLACE OF DEATH

County: Montgomery

City or town: Takoma Park Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 805 - Maple -

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME SARAH LOUELLA - OTTERMAN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowered

6.(b) Name of husband or wife: Harvey

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April - 28 - 1869

8. AGE: Years: 76 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Penna (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER — 12. Name: Joseph Boyd

FATHER — 13. Birthplace: Penna

MOTHER — 14. Maiden name: Adelia Wiedemon

MOTHER — 15. Birthplace: Penna

16. Informant: Catherine Otterman

Address: 6219 - 31. St NW

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 3/6/45 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: The S.H. Haines Co.

Address: 2401 - 14th St NW

19. 3-6 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 6, 1945, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2, 1945, to Mar. 6 1945; and that I last saw h... alive on Mar. 6, 1945.

	DURATION
Immediate cause of death: Congestive heart failure	1 day.
Due to: Arteriosclerosis	Indefinite.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 6911 5th St. N.W. Washington, D.C. Date signed: 3/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

03661

Reg. Dist. No. 223-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6926 Willow St.

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME

Oxley Oxley, Sarah Ellen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 2, 1869

8. AGE: Years	Months	Days	If less than one day
76		16	hrs. min.

9. Birthplace: Fort Williams, Ohio (Town, county, and state)

10. Usual occupation: Stenographer - retired

11. Industry or business

FATHER — 12. Name: — — — — — —

FATHER — 13. Birthplace: — — — — — —

MOTHER — 14. Maiden name: — — — — — —

MOTHER — 15. Birthplace: — — — — — —

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 22 1945 (month) (day) (year)

Cemetery or crematory:

Location: Battle Creek, Mich.

18. Funeral director: Arthur Zaltzer

Address: 254 Carroll St. N.W. Takoma Park D.C.

19. Mar 18 1945 (Date rec'd by registrar) J. Milton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/18/45 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/5 1945 to 3/18/45 and that I last saw h alive on 3/18/45

Immediate cause of death	DURATION
Coronary thrombosis	3 days
Due to: Generalized Arteriosclerosis	
Due to: Hypostatic Pneumonia	3 days
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Howard L. Brown M.D. M. D. or other

Address: 25 Carroll Ave Takoma Park Md Date signed: 3/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B1a)

03662

CERTIFICATE OF DEATH

Reg. Dist. No. 2-14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery.
City or town: Silver Springs
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 1206 Linden Lane
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Springs Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1206 Linden Lane
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Frank Marion Page

3. (b) Social Security Number.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed.

6 (b) Name of husband or wife: Isabella B Page
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 11 1856

8. AGE: Years: 88 | Months: 4 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Placerville California
(Town, county, and state)

10. Usual occupation: Clerical. Retired. Farmer "

11. Industry or business:

FATHER
12. Name: Horace Francis Page.
13. Birthplace: New York.

MOTHER
14. Maiden name: Jane Watters.
15. Birthplace: Richmond Virginia

16. Informant: Mrs. Mildred Page.
Address: 1206 Linden Lane.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 30. 1945 (month) (day) (year)
Cemetery or crematory: St Johns.
Location: Forest Glen - Manty Co. Md.

18. Funeral director: Wilkins & Pumphrey
Address: 8 & D & Ga Ave Silver Spring. Md

19. Mar. 28 1945 (Date rec'd by registrar) Josephine M Schaffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1945, at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935, to March 27 1945
and that I last saw him alive on March 27 1945

Immediate cause of death	DURATION
Congestive Heart failure	1 day.
Due to Arterio-Sclerosis	Undetermined
Due to	
Other conditions Arterio-Sclerotic nephritis	Undetermined

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clapham Pettigrew M.D. M. D. or other
Address: 1835 Eye St NW Date signed: 3-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

03663

CERTIFICATE OF DEATH

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15-4

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Washington County:

City or town: D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10-3rd St. S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Howard Pendagraph

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: NANNIE PENDAGRAPH

7. Birth date of deceased (mo., day, yr.): May 15 1894

6.(c) If alive, give age: 50 years

8. AGE: Years: 50 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: NEW RIVER TENN. (Town, county, and state)

10. Usual occupation: LABOR

11. Industry or business: LABOR

FATHER

12. Name: COULTER PENDAGRAPH

13. Birthplace: TENN.

MOTHER

14. Maiden name: MARY GOODE

15. Birthplace: TENN.

16. Informant: WIFE

Address: ABOVE

17. Removed (Burial, cremation, or removal. Which?) Date thereof March 1 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: Chas S Zurhorst Inc

Address: 301 East Capitol St.

19. 3/1 1945 Mrs E Jobes

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1, 1945 at 3:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sep. med. Exam case 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	1 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bronhurst M.D. M. D. or other

Address: Gaithersburg Md. Date signed: 3-1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

03064

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montg Co
City or town: Gaithersburg Md,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6Yr 5 Mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montg
City or town: Gaithersburg Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Martha Alice Perkins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

B.(b) Name of husband or wife: Louis Perkins
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1860 Oct 22

8. AGE: Years	Months	Days	If less than one day
1860 84	4	29	hrs. min.

9. Birthplace: Louden Co.Va,
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: James A Rollins
13. Birthplace: Va,

MOTHER
14. Maiden name: Martha A Hitaffer
15. Birthplace: Va,

16. Informant: Methodist Home, H M Wilson
Address: Gaithersburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/24/45 (month) (day) (year)
Cemetery or crematory: Union Cemetery
Location: Leesburg Va,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg Md

19. March 23 1945 - Alma L Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 19 45 at 10.45 Pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March - 18 - 19 45 to March - 21 - 19 45 - and that I last saw h alive on March - 21 - 19 45 -

Immediate cause of death: Broncho - pneumonia — DURATION: 5 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. C. Hilla, M.D.
M. D. or other
Address: Gaithersburg Md Date signed 3/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

03665

Reg. Diat. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life Time

Hospital, Institution, or street address where death occurred: 511 - East Monty Ave.

How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville (If outside city or town limits, write RURAL and give nearest town)

Street No. 511 - East Monty Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rosa Vaughn Prettyman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Charles H. Prettyman

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 24 - 1857

8. AGE: Years: 87 | Months: 8 | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Monty. Co - Maryland (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER — 12. Name: William Vies Bowie

13. Birthplace: Monty. Co - Maryland

MOTHER — 14. Maiden name: Mary Ann Dyer

15. Birthplace: Monty Co - Maryland

16. Informant: William F. Prettyman

Address: 511 - E. Monty Ave - Rockville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 31/45 (month) (day) (year)

Cemetery or crematory: Rockville Union Cem.

Location: Near Rockville - Md

16. Funeral director: Wm. Reuben Pumphrey

Address: Rockville - Maryland

19. 3/30/45 (Date rec'd by registrar) Josephine D. Moulton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1945 at 7 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1939 to March 29 1945

and that I last saw her alive on March 29 1945

	DURATION
Immediate cause of death: acute cardiac dilatation	1 hour
Due to: arteriosclerosis / Hypertension	10 yrs
Due to:	
Other conditions: Incomplete fracture left femur (hip)	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op. -

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. G. Smithmeyer M.D. M. D. or other

Address: Rockville, Md Date signed: 3/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-A

03665

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural) (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mo. 8 da.

Hospital, institution, or street address where death occurred: USNH, Bethesda, Md.

How long in hospital or institution? 5 mo. 8 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Ohio County:

City or town: Lorain (If outside city or town limits, write RURAL and give nearest town)

Street No. 122 Lwxington, Ave (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Nick James PUMA PFC USMCR

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-5-22

8. AGE: Years 22 | Months 6 | Days 20 | If less than one day: hrs. min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Marine corps

11. Industry or business:

FATHER 12. Name: Sam Puma

13. Birthplace: Sicly

MOTHER 14. Maiden name: Rose Morino

15. Birthplace: Ohio

16. Informant: Mo: Mrs. Rose Puma

Address: 1226 Lexington Ave, Lorain, Ohio

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3-26-45 (month) (day) (year)

Cemetery or crematory:

Location: Lorain, Ohio

18. Funeral director: W. M. Chambers W.A. MacLeer

Address: 1400 Chapin St. N.W. Wash, D. C.

19. 3-26-45 (Date rec'd by registrar) 45 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/25/45 19.... at .... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 17 19 44 to March 25 19 45 and that I last saw him alive on March 25, 1945 19....

Immediate cause of death	DURATION
Coplen's Anemia (adult type)	1 yr
Due to	2 mo
Due to	
Other conditions: mesenteric thrombosis; High small obstruction Jejunal	2 mo; 6 weeks

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Thomas L. Greason M.D. M. D. or other

Address: USNH Bethesda Md Date signed 3/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-c)

03067

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Monta

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Colesville Rd & East West Highway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 125 Oglethorpe St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John Christian Rau

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Emma Stall Rau

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 12 1869

8. AGE: Years	Months	Days	If less than one day
75	5	10	hrs. min.

9. Birthplace: West DC (Town, county, and state)

10. Usual occupation: retired electrician

11. Industry or business

FATHER — 12. Name: Herman A Rau

13. Birthplace: Germany

MOTHER — 14. Maiden name: Caroline A Christian

15. Birthplace: Germany

16. Informant: Cecil H. McLendon

Address: 125 Oglethorpe N W

17. Removal (Burial, cremation, or removal. Which?) Date thereof March 22 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington DC

18. Funeral director: Deal Funeral Home

Address: 4812 Ga Ave N W Wash DC

19. Mar. 22 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 22 19 45 at 4:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec Med Exam 19 to case 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Internal Hemorrhage	1 hr
Due to rupture of subclavian vein	1/2 hr
Automobile accident	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of 3-22-45

Where did injury occur? Silver Spring (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?): highway

Means of injury: auto accident Injured at work? ✓ no

23. SIGNATURE: Frank J. Borchardt M.D.

Dep Med Exam M. D. or other

Address: Gaithersburg Md Date signed 3-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12-a)

03068

CERTIFICATE OF DEATH

Reg. Dist. No. 716

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Chevy Chase Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 106 E. Thornapple
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Alice Hyatt Reid

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: George Conrad Reid
6(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): June 26" 1879

8. AGE: Years	Months	Days	If less than one day
65	9	5	hrs. min.

9. Birthplace: Hyattsville, Md. (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: Franck Hyatt
13. Birthplace: Hyattsville, Md.

MOTHER
14. Maiden name: Ella Carlton
15. Birthplace: Bladensburg, Md.

16. Informant: George Conrad Reid
Address: 106 E. Thornapple, St. Ch. Ch. Md

17. Ft. Lincoln. Burial (Burial, cremation, or removal. Which?) Date thereof April 2" 1945 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln
Location: Bladensburg, Md.

18. Funeral director: Harry L. Shye
Address: 1009 H, St. N.W. Wash. D.C.

19. 3/31 1945 (Date rec'd by registrar) Mrs E. Jones Registrar
80 M

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31" 1945, at 4306 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DEC. 1940 to MARCH 1945.
and that I last saw her alive on MARCH 30 1945.

	DURATION
Immediate cause of death: CEREBRAL HEMORRHAGE	
CARDIO-RESPIRATORY FAILURE	
Due to: CEREBRAL HEMORRHAGE	2 DAYS
Due to: HYPERTENSION	10 YEARS
CORONARY ARTERY DISEASE	
Other conditions: AORTITIS - AORTIC	INDEFINITE
REGURGITATION	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Russell T. Cahoon (Cahoon) M.D. (M. D. or other)
Address: 1726 EYE ST., N.W. WASH, D.C. Date signed 3/31/45.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

03069

Reg. Dist. No. 211

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Damascus Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Damascus
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Louis E. Rhinehart

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Antonia Rhinehart

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): February 5, 1873

8. AGE: Years: 72 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Baltimore County
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: Louis Rhinehart

13. Birthplace: Maryland.

MOTHER 14. Maiden name: Underdown

15. Birthplace

16. Informant: Mrs. Antonia Rhinehart

Address: Damascus, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: March 25 1945
(month) (day) (year)

Cemetery or crematory: Damascus, Md.

Location: Damascus, Montgomery

18. Funeral director: J. B. Beall, Inc.

Address: Damascus Md.

19. (Date rec'd by registrar) March 25 1945 Della V. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23, 1945, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16, 1943, to March 1945

and that I last saw h/M alive on March 21 1945

	DURATION
Immediate cause of death: Cerebral Thrombosis	4 Days.
Due to: Arteriosclerotic cardio vascular disease	10 years.
Due to: Senile Dementia	2 years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James P. Kerr M.D.
M. D. or other

Address: Damascus, Md. Date signed: 3/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1127-P)

03670

CERTIFICATE OF DEATH

Reg. Dist. No. 2/3-

1. PLACE OF DEATH
County Montgomery
City or town Damsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
Damsville
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Damsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Joseph C. Roberts

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Carrie Roberts
6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) January 23 - 1872

8. AGE: Years 73 | Months 1 | Days 14 | If less than one day ... hrs. ... min.

9. Birthplace Frederick Co - Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Robert Roberts
13. Birthplace Maryland

MOTHER 14. Maiden name Charlotte Ann Ritchie
15. Birthplace Maryland

16. Informant Mrs. Conley McLaughlin
Address Rockville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 13-1945 (month) (day) (year)

Cemetery or crematory Presbyterian Church Cem
Location Damsville - Maryland

18. Funeral director Wm Reuben Dunsbury
Address Rockville - Maryland

19. 3/12/45 (Date rec'd by registrar) Josephine D. Wootton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March - 9 - 1945 at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 29 - 1945 to March - 8 - 1945 and that I last saw h... alive on March - 8 - 1945.

	DURATION
Immediate cause of death: Gradual exhaustion	1 month
Due to: Refusing to eat	1½
Due to: senility	5 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William C Miller M.D.
M. D. or other
Address Gaithersburg, Md Date signed 3/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-2

CERTIFICATE OF DEATH

03071

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A16

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Md. (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 days

Hospital, institution, or street address where death occurred: US NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution? 41 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: N.J. County: Birlington

City or town: Vincentown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: RD #1

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SAINZ, Grace Viola

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Helver T. Sainz

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 24 August 1906

8. AGE: Years	Months	Days	If less than one day
38	6	21	..... hrs. ..... min.

9. Birthplace: Pa. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: Enos Shaub; 13. Birthplace: Pa.

MOTHER — 14. Maiden name: Lillian Shaub; 15. Birthplace: Pa.

16. Informant: husband: Helver T. Sainz

Address: 4601 Lewis Avenue, Suitland, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 3-19-45 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 3-16-45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 March 1945, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Feb. 1945, to 15 March 1945

and that I last saw her alive on 15 March 1945

	DURATION
Immediate cause of death: Heart failure	
Acute	
Due to: 2 Lymphosarcoma with metastasis	1 day 6 mos
Due to: Venous obstruction of vena cava due to	1 day
Other conditions: pressure from mediastinal lymph nodes.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Lymphosarcoma & metastasis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A. W. Polsinelli M. D. or other

Address: USNH Bethesda, Md. Date signed: 3-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03672

Reg. Diat. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? five days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? five days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa. County:

City or town: Altoona,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 209-17th Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SCHMIDHAMMER, Karl

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12-31-20

8. AGE: Years	Months	Days	If less than one day
24	2	1	hrs. min.

9. Birthplace: Pa.
(Town, county, and state)

10. Usual occupation: Marine Corps

11. Industry or business:

FATHER
12. Name: Albert JosephSchmidhammer
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Albert Joseph Schmidhammer (father)
Address: 209 17th St., Altoona, Pa.

17. removal (Burial, cremation, or removal. Which?) Date thereof 3-2-45 (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: W. W. Chambers
Address: 1400 Chapin Street, N. W., Wash., D.C.

19. 3-2 (Date rec'd by registrar) 19 45 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 March 19 45, at 0526 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam Case 19, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Compound fracture of skull	5 days
Due to: struck by street car	
Due to: in Wash. D.C.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidental Date of 2-25-45

Where did injury occur? Wash. (City or town) D.C. (County) (State)

Injured at home, farm, industry, public place (where?): Street

Means of injury: struck by street car Injured at work? no

23. SIGNATURE: Frank J. Bronhart M. D.
Dep Med. Exam M. D. or other

Address: Westminster md Date signed 3-2-45

3-2-45

REMAINS TURNED OVER TO DISTRICT OF COLUMBIA AUTHORITIES THIS DATE

Frank Broschart

Frank BROSCHART
Deputy Medical Examiner of
Montgomery

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03573

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Date of death verified and is correct. Dr. F. J. B. 5/31/45

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Monty.

City or town: Brookmont, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Monty.

City or town: Baltimore, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4814 Frederick Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alice M. Seguin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married.

6.(b) Name of husband or wife: Harry K.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 7, 1894

8. AGE: Years	Months	Days	If less than one day
50			hrs. min.

9. Birthplace: Charlestown W. Va.

(Town, county, and state)

10. Usual occupation: housewife.

11. Industry or business

FATHER — 12. Name: John Fisher

FATHER — 13. Birthplace: Va.

MOTHER — 14. Maiden name: Ellis ?

MOTHER — 15. Birthplace: Va.

16. Informant: Harry K. Seguin.

Address: 4814 Frederick Ave. Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/15/45 (month) (day) (year)

Cemetery or crematory: Rockville Union Cem.

Location: Rockville, Md.

18. Funeral director: Wm Rowlen Pumphrey

Address: 7557 Wis. Ave. Bethesda, Md.

19. Mar 15 1945 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 14 1945 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 9 1945 to Mar 14 1945 and that I last saw h alive on Mar 9 1945

Immediate cause of death	DURATION
Asphyxia	
Due to Hanging (suicide)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 4-14-45

Where did injury occur? Brookmont (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) C & O Feeder Canal

Means of injury Injured at work?

23. SIGNATURE: Frank J. Broccolat M. D.

Dep. Med. Exam. M. D. or other

Address: Gaithersburg, Md. Date signed 4-14-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

03074

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
714 Spring, St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 714 Spring St
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Julia A. Shaw

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John T. Shaw
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 7, 1857

8. AGE: Years 87 | Months 9 | Days 17 | If less than one day ... hrs. ... min.

9. Birthplace Montg. Co. Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business —

FATHER
12. Name — Riggs
13. Birthplace Maryland

MOTHER
14. Maiden name [illegible] Woodward
15. Birthplace —

16. Informant Mrs. Hallie Bramell
Address 714 Spring St., Sil. Spring, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Mar 26 - 1945 (month) (day) (year)
Cemetery or crematory Rockville Cemetery
Location Rockville - Md.

18. Funeral director Warner E. Pumphrey.
Address 8434 Ga. Ave. Silver Spring, Md.

19. Mar. 26 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1945, at 12:15 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 15 1945, to March 24 1945
and that I last saw h[illegible] alive on March 23 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	1 day
Due to Hypertension	
heart disease	
Due to	
Other conditions General arterio sclerosis	—

(Include pregnancy within 3 months of death)

Major findings of operation —
Date of op. —
Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE J. Marion Bamshead M.D.
M. D. or other
Address Silver Spring Date signed 3/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8a)

CERTIFICATE OF DEATH

03675

Reg. Diat. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? approximately 10 years

Hospital, Institution, or street address where death occurred: 5504 McKinley St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5504 McKinley St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Theo Shrewsbury

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Howard Shrewsbury

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 12-5-68

8. AGE: Years	Months	Days	If less than one day
77	3	3	..... hrs. ..... min.

9. Birthplace: Black River Falls Wisconsin
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Peter Hawkins
13. Birthplace: Wisconsin

MOTHER
14. Maiden name: Martha Benson
15. Birthplace: Wisconsin

16. Informant: Mrs. Llewellyn
Address: 5504 McKinley St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 21 1945 (month) (day) (year)

Cemetery or crematory: Arlington National Cem.

Location: Arlington, Va.

18. Funeral director: Wm. Reuben Pumphrey

Address: 7557 Wisconsin Ave Bethesda Md

19. 3/26 1945 Wm E Jobes
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 1945 at 6 00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1945, to March 18 1945 and that I last saw her alive on March 18 1945

Immediate cause of death	DURATION
Respiratory Failure	
Due to: Cardiac insufficiency	
Due to: Cerebral Hemorrhage	
Other conditions: Hypertension; Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank Jaggers M.D.
M. D. or other

Address: 550-17th St NW Washington DC Date signed:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03676

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: CHEVY CHASE, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
4908 WESTERN AVE. NW.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: PENNA. County:

City or town: HUNTINGDON PENN.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: GRACE METZ SIMPSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband ~~or wife~~: RICHARD M SIMPSON

7. Birth date of deceased (mo., day, yr.): OCT 9, 1904 6.(c) If alive, give age: — years

8. AGE: Years	Months	Days	If less than one day
40	3	25	..... hrs. ..... min.

9. Birthplace: MILL CREEK, PENNA.
(Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business: —

FATHER
12. Name: PORTER W METZ
13. Birthplace: MILL CREEK, PA.

MOTHER
14. Maiden name: MARY CLAUDIA RUDY
15. Birthplace: SCOTIA, PA.

16. Informant: RICHARD M SIMPSON
Address: 4908 WESTERN AVE NW

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: MAR. 9/45
(month) (day) (year)

Cemetery or crematory:

Location: HUNTINGDON, PENN.

16. Funeral director: HARRY F BROWN

Address: HUNTINGDON, PENN.

19. 3/7 19 45 Wm E Jackson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/6/45 19 ..... at 5 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 4 19 45, to March 6 19 45

and that I last saw h[e]r alive on March 6 19 45

Immediate cause of death: Congestive Heart Failure — DURATION: 1 week

Due to: Thrombosis of inferior Vena Cava — 1 year +

Due to: Primary Carcinoma of Liver — 1 year

Other conditions: — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Primary Carcinoma of Liver

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John B Marbury MD M. D. or other

Address: 1746 K St NW Wash DC Date signed: 3/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

03677

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 9/5 Viers Mill Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Rural (Laurel) (If outside city or town limits, write RURAL and give nearest town)
Street No.: Sandy Spring Road, (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Baby Slye

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 3, 1945

8. AGE: Years | Months | Days | If less than one day: 2 hrs. min.

9. Birthplace: Rockville (Town, county, and state)
10. Usual occupation: —
11. Industry or business: —
12. Father's Name: Gaynell J. Slye
13. Father's Birthplace: Shenandoah Co., Va.
14. Mother's Maiden name: Mildred Gertrude Barker
15. Mother's Birthplace: Cella, Baltimore Co., Md.
16. Informant: Mildred G. Slye
Address: Sandy Spring Rd. Laurel, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 5, 1945 (month) (day) (year)
Cemetery or crematory: Ivory Hill, Prince Geo. Co., Md.
Funeral Director's signature: Dewitt Donaldson
18. Funeral director:
Address: Laurel, Md.
19. 3/4/45 (Date rec'd by registrar) Josephine D. Hoatson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3, 1945, at 11:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3, 1945 to March 3, 1945 and that I last saw h[illegible] alive on March 3, 1945
Immediate cause of death: premature birth — DURATION
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G. O. Hartley, M.D. M. D. or other
Address: Rockville, Md. Date signed: 3/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 1A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03678

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution? 23 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. Colesville (In care of Jeanne Bennett)

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Dorothy Louise Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single.

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 24, 1935

8. AGE:

Years	Months	Days	If less than one day
9	9	11	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Child.

11. Industry or business

MOTHER FATHER

12. Name — — — — —

13. Birthplace — — — — —

MOTHER

14. Maiden name Frances Smith

15. Birthplace Washington, D.C.

16. Informant Hospital record.

Address — — — —

17. Buried (Burial, cremation, or removal. Which?) Date thereof March 14, 1945 (month) (day) (year)

Cemetery or crematory Rood Hope

Location Colesville, Md.

18. Funeral director Robert L. Snowden

Address 246 N. Wash. St. Rockville Md.

19. Mar. 14 1945 (Date rec'd by registrar) Gertrude B. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1945, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dept. Medicine 19 Exam case to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Septic pneumonia	4 days
Due to 1st & 2nd degree burns of lower abdomen, buttocks	23 days
Due to acid burns extremities	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 2-15-45

Where did injury occur? Silver Spring (City or town) Md. (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury burns Injured at work? no

23. SIGNATURE Frank J. Bronkat M.D. Dept. Med. Exam. M. D. or other

Address Gaithersburg Md Date signed 3-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462) K

03979

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Washington Sanitarium + Hospital

How long in hospital or institution? 43 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockwood

(If outside city or town limits, write RURAL and give nearest town)

Street No. Lacy Drive, Route 2

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mr. William Mora Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 21, 1882

8. AGE: Years	Months	Days	If less than one day
62	10	21	..... hrs. ..... min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Sheet metal worker

11. Industry or business

FATHER 12. Name - - - -

13. Birthplace - - - -

MOTHER 14. Maiden name - - - -

15. Birthplace - - - -

16. Informant Records Wash. Sani. + Hospital

Address Takoma Park, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof March 14 1945 (month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director W. W. Chambers Co.

Address 1400 Chapin St. N.W.

19. March 14 1945 (Date rec'd by registrar) J. Wilmer Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945, at 3 07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31 1945 to March 14 1945 and that I last saw him alive on March 13, 1945

Immediate cause of death Carcinoma of stomach & metastasis to liver and adjacent tissue — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations as above Date of op. Feb 21, 1945

Autopsy results O

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John F. Bowersox M.D. M. D. or other

Address ..... Date signed 3/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03080

Reg. Dist. No. 6/8

1. PLACE OF DEATH:
County Montgomery
City or town Howard Chapel RFD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Howard Chapel RFD 2 md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Sidney Snowden

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	col	married

6.(b) Name of husband or wife Benjamin
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28 1880

8. AGE: Years	Months	Days	If less than one day
64	3	11	hrs. min.

9. Birthplace Howard Co Md
(Town, county, and state)
10. Usual occupation House Wife
11. Industry or business Home
FATHER 12. Name William Tyler
13. Birthplace Frederick Md
MOTHER 14. Maiden name Martha Clark
15. Birthplace Baltimore Md
16. Informant Nanetta Darsey
Address Brookeville Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof March 14 1945 (month) (day) (year)
Cemetery or crematory Brown Chapel
Location Dayton Howard Co Md
18. Funeral director Roy W. Barber
Address Laytonsville Md
19. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1945, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1945, to March 11, 1945 and that I last saw h E.B. alive on March 11 1945

Immediate cause of death Extensive second and third degree burns of legs. — DURATION 2 days.
Due to Secondary Shock — 1 day.
Due to Arteriosclerosis — 10 years.
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James P. Kerr M.D.
M. D. or other
Address Damascus, Md. Date signed 3/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

03981

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:
County: Montg Co,
City or town: Gaithersburg Md (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 76yr
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montg
City or town: Gaithersburg Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Amanda Katherine Sparrow

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George W Sparrow
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 8th 1868

8. AGE: Years	Months	Days	If less than one day
1868 76	7	1	hrs. min.

9. Birthplace: Gaithersburg Md (Town, county, and state)
10. Usual occupation: House "ife
11. Industry or business

FATHER
12. Name: Richard Mills
13. Birthplace: Md,

MOTHER
14. Maiden name: Mary Saffel
15. Birthplace: Md

18. Informant: Clarence Sparrow
Address: Gaithersburg.Md,

17. Forc BURIAL Cemetery 3/12/45
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg Md,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg Md,

19 March 9 1945 Amanda G Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9th 1945, at 10.45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 19.. to Mar 9 1945
and that I last saw h... alive on Mar 3 1945

Immediate cause of death	DURATION
Carcinoma of stomach	1 yr.
Due to	
Due to	
Other conditions Chronic tonsilitis	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: F J Bronkart M.D.
M. D. or other
Address: Gaithersburg Md Date signed 3-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1142)

03682

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:-

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? One hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Mass. County

City or town Long Meadow Mass.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 147 Laurel St.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Stratton, Mrs. Jean

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife Stratton, Mr. George

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1880

8. AGE: Years 64 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Springfield (Town, county, and state) Mass.

10. Usual occupation Housewife.

11. Industry or business

FATHER 12. Name James Ritchie

13. Birthplace Scotland

MOTHER 14. Maiden name unknown

15. Birthplace unknown

16. Informant Allen R. Stratton

Address 5608 Lovelewick St. Bethesda, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 3/3/45 (month) (day) (year)

Cemetery or crematory Cedar Hill Cem.

Location Md.

18. Funeral director Wm. Reuben Humphreys

Address 7557 Wis. Ave. Bethesda, Md

19. 3/2 (Date rec'd by registrar) 19 45 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1/45 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 25 19 45 to March 1 19 45

and that I last saw her alive on February 28 19 45

Immediate cause of death	DURATION
Respiratory failure	
Due to Bronchial obstruction and atelectasis	
Due to mucous plug	
Other conditions Cardiac failure	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank Jogers M.D.

M. D. or other

Address 806 Georgetown Rd Bethesda Date signed 3/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on FILM No G94 MAY 15 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

CERTIFICATE OF DEATH

03683

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Mont. Co.

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 508 Wayne Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME SADIE SUSSAN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife SAMUEL SUSSAN

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) MAR 26 1883

8. AGE: Years	Months	Days	If less than one day
63 62		1	...hrs. ...min.

8. Birthplace Poland (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Philip Kurly

13. Birthplace Poland

MOTHER 14. Maiden name Sudnow

15. Birthplace Poland

16. Informant Philip D. Sussman

Address 508 Wayne Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 28 1945 (month) (day) (year)

Cemetery or crematory Brin Bryn Mawr Cem.

Location Oak Hill Cem. Prince Georges Co.

18. Funeral director B. Dansansky & Son

Address 3501-14th St. N.W. Washington D.C.

19. Mar. 27 1945 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1945 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1943 to Mar. 27 1945 and that I last saw h.er alive on Mar 27 1945

	DURATION
Immediate cause of death Coronary Thrombosis Cardiac Decompensation	10 hrs
Due to Arteriosclerotic heart disease with hypertension	20 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Erwin Steinman MD M. D. or other

Address 3500-14th St NW Date signed 3/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

03084

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Nov 11, 1941
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 9925 Markham St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alma Marie (Schraishuhn) Thompson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe.	White	married

6.(b) Name of husband or wife: Albert E. Thompson
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): June 2, 1890

8. AGE:

Years	Months	Days	If less than one day
54	9	22	hrs. min.

9. Birthplace: Philadelphia, Pa
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:

FATHER
12. Name: Harry Schraishuhn
13. Birthplace: Philadelphia

MOTHER
14. Maiden name: Margaret Rauchenberger
15. Birthplace: Mauch Chunk, Pa

16. Informant: Albert E. Thompson
Address: 9925 markham st Si. Spring.

17. Removal.
(Burial, cremation, or removal. Which?)
Date thereof: Mar. 24 1945
(month) (day) (year)

Cemetery or crematory:
Location: Philadelphia - Pa.

18. Funeral director: Warner E. Pumphrey.
Address: 8434 Ga Ave - Silver Spring - md.

19. Mar. 24 1945 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 1945, at 5 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 1944 to Mar 24 1945
and that I last saw her alive on March 23 1945

Immediate cause of death	DURATION
Carcinoma of uterus and adnexa	10 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Operated August 44 inoperable
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John N. Andrew M. D.
Address: Silver Spring, Md
M. D. or other
Date signed: 5-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

03085

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 72-a

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montg Co,
City or town: Suburban HOSP, Bethesda Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Minutes
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 10 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md, County: Montg,
City or town: Gaithersburg. Md,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Edward Ellsworth Thompson.Jr,

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 28 1941

8. AGE: Years	Months	Days	If less than one day
3	4	0	..... hrs. ..... min.

9. Birthplace: Gaithersburg. Md,
(Town, county, and state)

10. Usual occupation: " "

11. Industry or business: " "

FATHER
12. Name: Edward Ellsworth Thompson
13. Birthplace: Gaithersburg, Md,

MOTHER
14. Maiden name: Betty Jane Reed
15. Birthplace: Washington D C

16. Informant: Betty Jane Reed, Thompson
Address: Gaithersburg. Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/31/45 (month) (day) (year)
Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg. Md,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg. Md,

19 March 31 1945 (Date rec'd by registrar) Alvin L. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28th 19 45, at 6.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam Case 19 ..... to ..... 19 .....
and that I last saw h ..... alive on ..... 19 .....

	DURATION
Immediate cause of death	
Purpura Hemorrhagica	
Due to Strep. Septicemia	23 hr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Brochart M. D.
Dep. Med. Exam.
M. D. or other
Address: Gaithersburg Md Date signed 3-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

03686

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 hours
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 17 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D/C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2132 Bancroft Place, N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: THOMPSON, Terry Brewster, Captain USN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Leita Thompson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 15 Feb. 1891

8. AGE: Years	Months	Days	If less than one day
54	0	21	hrs. min.

8. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Navy
11. Industry or business:

FATHER
12. Name: Charles Thompson
13. Birthplace: Mich. (deceased)

MOTHER
14. Maiden name: Flora McDonald
15. Birthplace: Wis.

16. Informant: Wife: Mrs. Leita Thompson
Address: 2132 Bancroft Place, N. W., Wash., D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 3-8-45 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. Chambers S.A. Nash
Address: 1400 Chapin St., N. W.

19. March 6 1945 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1945, at 0920 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 March 1945, to March 6 1945
and that I last saw him alive on March 6 1945

Immediate cause of death	DURATION
Diabetic Coma	14 hours
Due to: Diabetes mellitus	—
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: study incomplete Rm fx
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John E Gardner MC USNR
M. D. or other
Address: USNaval Hospital, Bethesda Md. Date signed: 3-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-0)

03687

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 4600 Walsh St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Monty.
City or town: Chevy Chase Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4600 Walsh St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Walter S. Thompson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Bessie M.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Feb. 23, 1880

8. AGE: Years	Months	Days	If less than one day
65			..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Postal Servt.
11. Industry or business:
FATHER 12. Name: Samuel Frank Thompson
13. Birthplace: Maryland
MOTHER 14. Maiden name: Emma Hastings
15. Birthplace: Maryland
16. Informant: Louise Bagley Daughter
Address: Same.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/13/45 (month) (day) (year)
Cemetery or crematory: Rockville Union Cem.
Location: Rockville, Md.
18. Funeral director: Wm. Reuben Pumphrey
Address: 7557 Wis. Ave. Bethesda
19. 3-13-45 (Date rec'd by registrar) 19..... [illegible] Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11, 1945, at 6:15 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/3 1944 to 3/5 1945
and that I last saw him alive on 3/5 1945

Immediate cause of death	DURATION
respiratory failure	
Due to: cerebral hemorrhage	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. L. Marks, M.D.
M. D. or other
Address: 4601 Leland St. Date signed: 3/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

03088

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23

Hospital, institution, or street address where death occurred: 37 Sycamore ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 37 - Sycamore Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Scott WALL

3.(b) Social Security Number

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: Edward Wall

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Mar. 27 - 1856

8. AGE: Years 89 Months Days 2 If less than one day ... hrs. ... min.

9. Birthplace: Richmond - Va.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Edwin H. Chamberlayne

13. Birthplace: Richmond - Va.

MOTHER

14. Maiden name: Sarah M. Scott

15. Birthplace: Richmond - Va.

16. Informant: Mary C. W. Gregg

Address: 37 - Sycamore Ave

17. Removal Date thereof: Mar. 29 - 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location: Washington, D.C.

18. Funeral director: Joseph Gawler's Sons

Address: 1756 - Pa. Ave. N.W. Wash. D.C.

19. Mar. 29 1945 J. Wilson Dodd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 29 1945, at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 29, 1945, to ... 19..

and that I last saw her alive on Mar. 29, 1945.

	DURATION
Immediate cause of death: Congestive heart failure	Suddenly
Due to: arterio-sclerosis	Indefinite
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide (None) Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. B. Little, M.D.
M. D. or other

Address: 6911 5th St. N.W. Wash. D.C. Date signed 3/29/45

Signed by director of the
Coroner of Montgomery County.
Death obviously due to
natural causes. B Fiddler Med.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73)

03089

CERTIFICATE OF DEATH

Reg. Diat. No. 716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? six days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montg
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9507 Gatewood
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Whitmeyer

3.(b) Social Security Number: 094-05-8211 A.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mrs Madge Whitmeyer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 5. 1874

8. AGE:

Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace: Otta, N. Y.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Nicholaus Whitmeyer
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine S Kerr
15. Birthplace: N. Y.

16. Informant: Donald Whitmeyer
Address: 306 Indian Sp. Dr. Silver Spring Md.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 3/21/45 (month) (day) (year)
Cemetery or crematory: Liberty Park Cem
Location: Catonsville Md.

18. Funeral director: Wm Reuben Hemphill
Address: 1557 Wis. Ave. Bethesda

19. 3/21 19 45 Wm E Jobes Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 19 45 at 12:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 19 45 to March 18 19 45
and that I last saw him alive on March 17 19 45

Immediate cause of death	DURATION
Broncho pneumonia (acute)	11 days
Due to	
Due to	
Due to Hypertensive Heart	
Other conditions Wild Myocardial Failure	2 yrs. (Hist.)

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James F. O'Donnell M. D. or other
Address: 4302 E W Highway Bethesda Md Date signed 3/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 520 K

CERTIFICATE OF DEATH

03090

Reg. Dist. No. " 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months 15 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1250 Simms Pl., N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: WRIGHT, Charles (n) CBM USN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-us	married

6.(b) Name of husband or wife: Mrs. Mary V. Wright
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 12, 1892

8. AGE: Years	Months	Days	If less than one day
52	8	10	hrs. min.

9. Birthplace: Pa.
(Town, county, and state)
10. Usual occupation: Navy
11. Industry or business:

FATHER
12. Name: Amos Wright
13. Birthplace: Pa. (deceased)

MOTHER
14. Maiden name: Frances Burns
15. Birthplace: J.J.

16. Informant: Wife: Mrs. Mary V. Wright
Address: 1250 Simms Pl., N.E., Wash., D.C.
17. burial (Burial, cremation, or removal. Which?) Date thereof 3-26-45 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.
18. Funeral director: W. W. Chambers,
Address: 517 11th St. S. E., Wash., D.C.
19. March 22 19 45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 19 45 at 1 p. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 Dec. 19 44 to 22 Mar 19 45
and that I last saw h im alive on 22 March 19 45

	DURATION
Immediate cause of death: Carcinoma, rt. lung Metastetic	3 mos ?
Due to: Carcinoma (Hyper-Nephroma) Right Kidney	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Above —
Date of op. 21 Mar 1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E. M. Kent
E, M. KENT, Lt. Comdr. (MC) USNR
M. D. or other
Address: US NAVAL HOSPITAL, Bethesda, Md. Date signed: 3-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for addition of residence of deceased is shown on

FILM No. G 94 MAY 15 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

03091

Reg. Dist. No. 316

1. PLACE OF DEATH:

County Mont County Md.

City or town Chevy Chase Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6303 Georgia St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Samuel S Yoder Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Dorothy Puhn Yoder

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 9 1886

8. AGE: Years	Months	Days	If less than one day
59			..... hrs. ..... min.

9. Birthplace Lima Ohio
(Town, county, and state)

10. Usual occupation Accountant

11. Industry or business Treasury Department

FATHER 12. Name Samuel S Yoder

FATHER 13. Birthplace Berlin Ohio

MOTHER 14. Maiden name Theresa E. Ellis

MOTHER 15. Birthplace Berlin Ohio

16. Informant Dorothy Yoder Wife

Address 6303 Georgia Ave Chevy Chase Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof March 4 1945 (month) (day) (year)

Cemetery or crematory Lee Funeral Home

Location 3001 4½ St and Mass Ave N.E.

18. Funeral director Wm Lee Sons Co

Address 4½ and Mass ave N.E. D.C.

19. 3/3 1945 (Date rec'd by registrar) Wm E Joles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1945, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 1944 to March 2 1945 and that I last saw him alive on March 1, 1945

Immediate cause of death	DURATION
Congestive Heart Failure	3 days
Due to Carcinomatosis - Pancreas - renal disease with	
Due to Hypertension	2 years
Other conditions Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Sidney Shapiro M.D.
Ingomar NW
M. D. or other

Address 3921 Ingomar St NW Date signed 3/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1/4 of 000
100 000
25 000
4 000
1 000
@ 1.00

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (746)

03092

CERTIFICATE OF DEATH

Reg. Diat. No. 716

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 11 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Virginia County Arlington
City or town Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2904 S. Jang St
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Charles E. Young

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife Frances Young. 6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) March 17, 1876

8. AGE: Years	Months	Days	If less than one day
68	11	17	hrs. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business "

FATHER 12. Name James Young
13. Birthplace Va

MOTHER 14. Maiden name Sis Huntington
15. Birthplace Va.

16. Informant Frances Young
Address 2904 S. Jang. St.

17. Removal 3-6-45 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory
Location
18. Funeral director Cunningham Funeral Home
Address Alexandria, Va.

19. 3/6 1945 Wm E. Jarboe Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar - 6 1945, at 12.30A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute myocardial failure	
Due to	
Due to	
Other conditions Acute Myelogenous Leukemia	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. Keith Cromer M. D. or other
Address U.S. Naval Hosp. Wash. D.C Date signed 3/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

03093

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5501 Leland St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Hoover M. Zook

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Wilma Zook

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Mar 10 1885

8. AGE:

Years	Months	Days	If less than one day
59	11	33	...hrs. ...min.

9. Birthplace: Washington DC

(Town, county, and state)

10. Usual occupation:

11. Industry or business: clothing business

FATHER

12. Name: Leander Zook

13. Birthplace: Pa

MOTHER

14. Maiden name: Alice Merrick

15. Birthplace: W. Va

16. Informant: Dewitt W. Zook

Address: 7027 Eastern Ave - Takoma Pk - Md

17. Burial (Burial, cremation, or removal, which?) Date thereof March 5 1945 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Bolivar, W. Va Jefferson Co.

18. Funeral director: J. Arthur Dalters

Address: 251 Carroll St., Takoma Park, D.C.

19. 3/3 1945 (Date rec'd by registrar) Wm E Dobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 1945, at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. med. Exam 19... to ...19...

and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death:	
Coronary occlusion	Last
Due to:	suddenly
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bouchard M.D.

Post. Exam M. D. or other

Address: Westminster Md. Date signed 3-3-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING